







Digitized by the Internet Archive  
in 2022 with funding from  
University of Toronto

<https://archive.org/details/31761114671639>











CA20N

XC 12

-577

S-21



S-21

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 16 November 1993

# Journal des débats (Hansard)

Mardi 16 novembre 1993

## Standing committee on social development

## Comité permanent des affaires sociales

Expenditure Control Plan Statute Law  
Amendment Act, 1993

Loi de 1993 modifiant des lois  
en ce qui concerne  
le Plan de contrôle des dépenses

Subcommittee report

Rapport de sous-comité

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 16 November 1993

The committee met at 1554 in room 151.

EXPENDITURE CONTROL PLAN STATUTE LAW  
AMENDMENT ACT, 1993

LOI DE 1993 MODIFIANT DES LOIS  
EN CE QUI CONCERNE  
LE PLAN DE CONTRÔLE DES DÉPENSES

Consideration of Bill 50, An Act to implement the Government's expenditure control plan and, in that connection, to amend the Health Insurance Act and the Hospital Labour Disputes Arbitration Act / Projet de loi 50, Loi visant à mettre en oeuvre le Plan de contrôle des dépenses du gouvernement et modifiant la Loi sur l'assurance-santé et la Loi sur l'arbitrage des conflits de travail dans les hôpitaux.

**The Vice-Chair (Mr Ron Eddy):** Good afternoon. The standing committee on social development is now in session on Bill 50, An Act to implement the Government's expenditure control plan and, in that connection, to amend the Health Insurance Act and the Hospital Labour Disputes Arbitration Act. We're in clause-by-clause consideration of the bill and Mr Wessinger had introduced a government amendment to subsection 2(3.3) of the bill. There had been some discussion. I understand discussion was almost concluded on that particular amendment. Further discussion at this time?

**Mr Jim Wilson (Simcoe West):** Sorry, Mr Chair, could you repeat that, please?

**The Vice-Chair:** An amendment by Mr Wessinger to amend subsection 2(3.3) of the bill was under discussion when the committee adjourned yesterday, I understand. The motion had been read and partially debated.

**Mr Jim Wilson:** What is the motion?

**Mrs Barbara Sullivan (Halton Centre):** This is the third-party services. I think we have basically concluded discussion on this section. Once again, I'll reiterate that in my view the amendment is premature because the homework hasn't been done, but none the less we're willing to go to a vote on it.

**The Vice-Chair:** Anyone else wish to speak to the matter? No. In that case, all in favour of the amendment presented? Carried.

The next is a Liberal amendment to subsection 2(3.1) of the bill.

**Mrs Sullivan:** I gather that the Conservative amendment is still to be stood down for the time being.

**Mr Paul Wessinger (Simcoe Centre):** Yes.

**The Vice-Chair:** Yes, that's recorded as being stood down and will be dealt with later in the meeting in effect.

**Mrs Sullivan:** I move that section 2 of the bill be amended by adding the following subsection:

"(3.1) The act is amended by adding the following sections:

"Duty to report

"43.1(1) A prescribed person who, in the course of his or her professional or official duties, has reasonable grounds to believe that another person has contravened section 43 shall promptly report the belief and the information on which it is based to the general manager.

"Subsection (1) prevails

"(2) Subsection (1) applies even if the information reported is confidential or privileged and despite any act, regulation or other law prohibiting disclosure of the information.

"Protection from liability

"(3) No proceeding for making a report under subsection (1), or for providing information in connection with the report, shall be commenced against a person unless he or she acts maliciously and without reasonable grounds for the belief.

"Exception: solicitor-client privilege

"(4) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client."

Mr Chairman, as you know, in the public hearing phase we had many interventions with respect to how an organization or a prescribed person would report what is basically the limited issue of health card fraud or when a person who is not an insured person attempts to receive an insured service. The original amendments which the government circulated to us would have allowed a prescribed person to report to the general manager of OHIP if a person were not a resident. That was clearly not acceptable. I think we did a fair canvass of the professions and facilities that appeared before us. They indicated that it would be impossible for them to make a judgement about the residency of a person, know what tests would have to be applied and so on. So clearly that test was not going to work.

What we were going back to in fact, in having this amendment in front of us at all, was the agreement with the OMA and the government that has specific sections included in it with respect to the reporting of health card fraud. The government has agreed to certain issues. I'd like to read, if I may, just a part of these discussions, what the Ontario Medical Association has agreed to:

"1. In exchange for one-time payment of claims under the J-8 rules, physicians will provide the Ministry of Health with the health number and other corroborating information about the cardholder (address, date of birth, name etc.) The mechanism for providing this information will be developed by the MOH-OMA joint working group."

Then the second section of that particular portion of the agreement relates to the physician actually picking up the card, the person surrendering the card to the physician. We have dealt with that in the previous section.

As you recall, when the committee had its public



hearings, there was a considerable difference of opinion with respect to whether this reporting should be mandatory or whether the reporting should be voluntary. We heard testimony from the medical association and we heard testimony from the College of Physicians and Surgeons of Ontario. As we were doing our homework in this area, we looked at other tests that are applied in other acts, and the test that appeared to be most comparable was that of the Child and Family Services Act, which has a requirement for reporting based on reasonable grounds to believe that certain circumstances have occurred, in the case of that act that a child has been abused.

#### 1600

I frankly, and after discussion with my colleagues, have opted for the mandatory reporting, because I'm convinced by the arguments that were put forward and by those which appear to have worked and have been familiar to practitioners in other areas. I should also say that these were not taken lightly. I thought that many of the arguments the CPSO put forward with respect to the disciplinary action which could be taken against a physician who has perhaps an obligation and perhaps not an obligation to report were problematic. So that was one area I thought was a useful addition to our hearings.

You will recall that in the government's initial proposals there was another section, with respect to voluntary reporting, whereby either a person or a prescribed person or whatever, depending on what the final wording would be, could voluntarily report to the minister on any other matter affecting the administration of OHIP. That voluntary reporting section—this is totally apart from the mandatory section at the beginning which was put forward by the government—is one that I found deeply offensive and quite worrisome, because that section would override the Public Hospitals Act, the Mental Health Act, the freedom of information act and several other scenarios which may well be required by the colleges with respect to their own professions.

As a consequence, this amendment is drafted so that if we refer back to the Health Insurance Act, what we are really trying to root out here in every case, whether it's the patient or whether it's the professional or whether it's anyone else, is the identification of a person who, on reasonable grounds, another person believes is committing fraud or who is receiving services when that person is not an insured person.

As a consequence, the reference is made directly back to section 43 of the Health Insurance Act, which I have here somewhere, which basically documents who is entitled to services, who is an insured person, and provides that the fraud surround—that's already in the act. The fraud surround is already here in section 43, if I can just read this:

"(1) No person shall knowingly obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that the person is not entitled to obtain or receive under this act and the regulations.

"(2) No person shall knowingly aid or abet another person to obtain or attempt to obtain payment for or

receive or attempt to receive the benefit of any insured service that such other person is not entitled to obtain or receive under this act and the regulations.

"(3) No person shall knowingly give false information in an application, return or statement made to the plan or to the general manager in respect of any matter under this act or the regulations."

The act spells out those offences already, so what we're saying is that for anyone who has reasonable grounds to believe in all of those circumstances that an offence has been committed or somebody has contravened that section, then that information should be reported.

In terms of the test of reasonable grounds, I have circulated documentation with respect to the test of legal grounds. You know I'm not a lawyer so I have to rely on people who have done the legal research. The legislative research service has provided a fairly good history of the meaning of the test of reasonable grounds to believe, and in my view it's a high test. The liability with respect to the reporting is covered in my amendment, and I recommend it to the committee.

**Mr Jim Wilson:** I appreciate Mrs Sullivan's comments with respect to this issue. However, I beg to disagree on some of the points contained in her argument. Members will note that they stood down the PC motion of yesterday which, rather than relying on a reasonable grounds test, introduces "has knowledge that an event referred to in subsection (2) has occurred shall promptly report the matter to the general manager."

After a lot of soul-searching and a great deal of compromise and good work on behalf of the OMA and the College of Physicians and Surgeons, I believe we have agreement that the PC motion that was stood down—and I will have to change that motion slightly and re-read it into the record today. None the less, I think it is a better approach and that we have agreement from the parties. After all, if we don't have agreement from the parties with respect to this issue, we can't expect much enforcement after this law is passed.

I think it's important that the parties to the act feel comfortable. It's my understanding, unless I'm corrected by someone in the room here, that the OMA and the CPSO are more comfortable with the PC motion, and hence I will not be supporting the Liberal motion put forward by Mrs Sullivan.

**Mr Wessinger:** I'd just like to also indicate that I believe the PC motion is preferable to the Liberal motion, based on some of the comments made by Mr Wilson and also based on the fact that I think it's an interesting compromise having both the mandatory and voluntary reporting in the motion. The motion will also contain a defence provision which, in the event of not reporting immediately in certain circumstances, I think might be appropriate, something that has also been requested by the Ontario Medical Association in the sense of very unstable patients. I think it's a much better motion and for that reason will not be supporting the Liberal one but will be supporting the PC one.



1610

**The Vice-Chair:** Any further discussion on the proposed amendment?

**Mrs Sullivan:** The Conservative amendment has not been presented yet. However, we understand that they are both going to have to be discussed before a vote is taken. I would like to hear more from the parliamentary assistant with respect to the override which is included in the Conservative motion. Under "Voluntary reporting," it says, "(4) A person may report to the general manager any matter...."

I suggest to you again that this is an override on the Public Hospitals Act, the Mental Health Act and the freedom of information act, and whether it's relating to the administration of this act or not, the only issues that can be reported now by professionals to OHIP are with respect to the services rendered and the cost of those services.

The public hospitals who appeared before this committee were very concerned and indicated in their testimony that they were concerned with this override. We did not have extensive hearings and we did not have people, by example, representing the psychiatric patients who are affected under the Mental Health Act, and other people affected under that act.

I think that this override is far more difficult to deal with than the issue of whether it's a reasonable-grounds test or whether it's a knowledge test. Frankly, I know the OMA wants the knowledge test; that's fine, but let's look at the voluntary reporting section. That is far more serious and has far more repercussions in terms of the health care system than whether a person reports with knowledge or on reasonable grounds to believe.

I respectfully submit to this committee that this bill is being written not only in the context of an agreement between the OMA and the government, but most of its sections affect providers and practitioners who are well beyond the scope of that agreement, and ultimately patients.

**The Vice-Chair:** Mr Wessinger, would you like to respond?

**Mr Wessinger:** Yes, I would like to respond. First of all, I think it should be clear that any information given to the general manager is covered by the freedom of information act, so that any of the information provided to the general manager will be subject to that act.

Secondly, the OMA has indicated that there would not be any reporting without this override. It was also indicated by the OMA that unless the override is there it would be considered professional misconduct under the RHPA if they didn't have the override provisions.

**Mr Jim Wilson:** I just want to correct my record. I had referred to the PC motion of yesterday as having been stood down. I understand it was deferred. I am looking for your direction, Mr Chairman, with respect to this motion. I guess the way the amendments were drafted, they're contained in different sections, so we're dealing with the Liberal motion first because the PC motion was deferred.

**Mrs Sullivan:** We deferred a different motion.

**Mr Jim Wilson:** No, we stood down a different motion.

**The Vice-Chair:** No.

**Mr Jim Wilson:** Maybe you want to correct me on this. I'm sorry; I was on my deathbed yesterday and I've been hauled off it to try and straighten this mess out.

**The Vice-Chair:** We appreciate your being here today, Mr Wilson. I believe the proposed PC amendment that was stood down was an amendment to 2(3.1) and sections 26.1 and 26.2, which will come up later. Are you speaking to PC amendment 2(3.2)?

**Mr Jim Wilson:** Yes.

**Mrs Sullivan:** Yes.

**The Vice-Chair:** My understanding is this will come up immediately after this.

**Mr Jim Wilson:** So your advice would be to deal with the motion on the floor now and then deal with the PC amendment.

My only thought on this was, regardless of when it was introduced or not introduced, Mrs Sullivan and I are referring to it, yet for the general public and for committee members it's not actually on the table or read into the record.

**The Vice-Chair:** Thank you for bringing that to our attention. You are right in that regard.

Any further discussion? If not, shall the proposed amendment to subsection 2(3.1) of the bill, section 43.1 of the Health Insurance Act, carry? The amendment is lost.

We'll proceed then to the PC proposed amendment to subsection 2(3.2).

**Mr Jim Wilson:** I move that section 2 of the bill be amended by adding the following subsection:

"(3.2) The act is amended by adding the following section:

"Mandatory reporting

"43.1(1) A prescribed person who, in the course of his or her professional or official duties, has knowledge that an event referred to in subsection (2) has occurred shall promptly report the matter to the general manager.

"Events

"(2) Subsection (1) applies to the following events:

"1. An ineligible person receives or attempts to receive an insured service as if he or she were an insured person.

"2. An ineligible person obtains or attempts to obtain reimbursement by the plan for money paid for an insured service as if he or she were an insured person.

"3. An ineligible person, in an application, return or statement made to the plan or the general manager, gives false information about his or her residency.

"Definition, 'ineligible person'

"(3) In subsection (2), 'ineligible person' means a person who is neither an insured person nor entitled to become one.

"Defence

"(4) It is a defence to a proceeding for failure to make a report required by subsection (1) that the prescribed



person delayed making the report because he or she believed on reasonable grounds that making the report might be a direct and immediate cause of serious bodily harm to a person and made the report as soon as he or she was of the opinion that the danger no longer existed.

**"Voluntary reporting"**

I'm going to add a word here in my reading of the amendment.

"(5) A prescribed person may report to the general manager any matter relating to the administration or enforcement of this act or the regulations.

"Subsections (1) and (5) prevail

"(6) Subsections (1) and (5) apply even if the information reported is confidential or privileged and despite any act, regulation or other law prohibiting disclosure of the information.

"Protection from liability

"(7) No proceeding for making a report under subsection (1) or (5) or for providing information in connection with the report shall be commenced against a person unless he or she acts maliciously and the information on which the report is based is not true.

"Exception: solicitor-client privilege

"(8) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client."

As I expressed earlier, this is a compromise amendment. I believe we have agreement from the Ontario Medical Association and the College of Physicians and Surgeons. It has incorporated, I think in a rather ingenious way, both mandatory reporting and voluntary reporting.

I would again ask the government and perhaps legal counsel to clarify for the record subsection (5) here, which deals with voluntary reporting. Certainly my reading of this amendment would in no way provide the override that Mrs Sullivan discussed in her previous comments.

Certainly the intent of both the mandatory and voluntary reporting cannot be missed, and that is that we had a very flawed health card system introduced by the previous government, and I appreciate the mea culpa with respect to this matter. But both the mandatory and voluntary provisions of this amendment would ensure that all parties with respect to health cards understand what their responsibilities are and also what their rights are. I think we need a zero tolerance approach towards fraud and this amendment is, I think, the best approach that we're able to come up with at this time.

Having said that, I'm not totally thrilled with the overall bill itself and will vote accordingly. However, I would ask for the support of the committee members with respect to this motion.

1620

**The Vice-Chair:** Thank you. Further discussion? Mrs Sullivan, please.

**Mrs Sullivan:** In this discussion, I want to go back to section 43 of the Health Insurance Act. Two subsections of section 43 relate to patients who are obtaining services for which they are not insured.

The first relates to persons who "knowingly obtain or attempt to obtain payment" or services when they are not entitled to those services.

The second relates to persons who help another person to fraudulently receive health care services. Those are offences under the act.

The offences that are included in terms of this amendment under subsections (1) and (2) in fact reflect the offences that are now included in the act.

Under subsection (3), however, there is a totally different interpretation of an offence. Under subsection (3) of the act it says, "No person shall knowingly give false information in an application, return or statement made to the plan or to the general manager in respect of any matter under this act or the regulations."

That section is particularly included in the Health Insurance Act to deal with those instances of professional fraud where they occur: the physician or other person who bills the plan for services which did not take place, billing for services which were medically unnecessary etc, and there are other places in the Health Insurance Act in those circumstances where the general manager can act.

In this draft of this bill, what we are saying is that it's an ineligible person who makes a false statement in an application. What happened to the professional fraud? All of a sudden all of the fraud, by implication, that occurs in this system—and in my view, we don't know how much fraud exists. I think that we've had one sloppy report from the Ministry of Health and that's about it; the rest is mostly anecdotal. The offences in this particular draft amendment do not match the existing act.

Secondly, under the voluntary reporting, I suggest to you that the test which is given for professionals and practitioners and their agents to report when they have knowledge of fraud is quite different than the test which is now being asked of people who may well know where there is professional or other fraud of that nature. In other words, you must have knowledge and you must report if you are a professional or a professional's agent with respect to a person who is ineligible.

However, the reverse circumstance doesn't take place. If you have knowledge of a professional fraud or fraud by an agent, you don't have to report; you "may" report. So you've got one standard of reporting in one circumstance and a totally different standard of reporting in another circumstance. I suggest to you that you've defeated the wrong amendment.

**Mr Wessenger:** I'd just like to reply. The purpose of this section really is only to deal with health card fraud and not to deal with other types of fraud, for instance, particularly with respect to the health provider.

First of all, I would suggest that any providers involved in fraud would be subject to a criminal offence anyway if they were in fact doing such an act.

**Mrs Sullivan:** It's a criminal offence under the act anyhow, for a person.

**Mr Wessenger:** That's right; it is an offence. But I would think the appropriate place to deal with this would be under the regulations in the Regulated Health Pro-

fessions Act under the whole question of professional misconduct. To my way of thinking, that would be the appropriate way to deal with behaviour that is illegal.

**Mrs Sullivan:** Then might I ask why the voluntary reporting provision is in this amendment?

**Mr Jim Wilson:** Might I respond to that, Mr Chairman? Members have to keep in mind that when I read the amendment into the record—we're talking about a prescribed person so I don't think we have just anybody running around reporting to the general manager. I think that's an important point.

Secondly, I think it's an onus on legislators to ensure that the public has some protection with respect to this matter, ie, it's a two-way street. It may be that physicians encounter fraud from members of the public, and it may be that other prescribed persons know of fraud occurring perhaps by physicians. Let's be real; it's a two-way street here.

If I were the government I would want this voluntary reporting provision included in this legislation. I think what it does then is if a prescribed person—it says, "may report to the general manager any matter relating to the administration or enforcement of this act or the regulations," and do so voluntarily. It's less draconian in a voluntary manner. We don't want to discourage people from reporting fraud. At the same time, if they do, we want to ensure that they're protected from liability so that there isn't a barrier to reporting.

I wish it were a perfect world and I wish we didn't have fraud occurring, but we know that it's several hundred million dollars' worth of fraud, at least potential fraud, in the system, and we as legislators have a responsibility to crack down on this as best we can and in the most humane way we can. I think that's what this amendment attempts to do.

**Mrs Sullivan:** Could I then ask the third party critic why the offence that is delineated in this amendment is different from the offences which are delineated in the current act?

**Mr Jim Wilson:** I'm going to sound a bit like Mr Wessenger with respect to my answers, but as I said, it's not a perfect world. I think it's the best we're going to do. If Mrs Sullivan wants to take a recess and try and hash this out with the groups that are most affected, fine. I will tell you, at the end of the day, you will come up with this wording.

**The Vice-Chair:** Any other discussion? If not, a vote on Mr Wilson's motion. All in favour? Opposed? Carried.

Next is a government motion, an amendment to subsection 2(3.4) of the bill.

**Mr Wessenger:** Is this dealing with the same matter, mandatory reporting? If it's section 43.1, I would ask that it be withdrawn.

**The Vice-Chair:** Withdrawn? Agreed. Mr Wilson.

**Mr Jim Wilson:** I believe we're about to deal with the PC motion that was stood down yesterday, subsection 2(3.1).

**The Vice-Chair:** No. It's my understanding it will be dealt with at the end of the motions that were recorded.

**Mr Wessenger:** Mr Chair, I think we should deal with it first, because otherwise motion 45.1 would be out of order. So we should deal with the stood-down motion now, at this stage.

**The Vice-Chair:** Do members of the committee agree then that we will deal with the PC motion that was presented yesterday by Ms Cunningham and stood down? Agreed.

**Mr Wessenger:** I wonder if Mr Wilson might wish to stand down his further until we deal with the government motion dealing with the same section.

**Mr Jim Wilson:** Agreed.

**The Vice-Chair:** Does the committee agree? Thank you.

**1630**

**Mr Wessenger:** I move that section 2 of the bill be amended by adding the following subsection:

"(3.2.1) The act is amended by adding the following section:

"Agreement with OMA re payments

"26.1(1) Despite anything else in this act, if an agreement between Her Majesty in right of Ontario, or the minister, and the Ontario Medical Association so provides, the general manager shall,

"(a) decrease, by an amount determined in accordance with the regulations, the amount of a payment that would otherwise be made by the plan to a physician or other person for insured services rendered in Ontario by a physician;

"(b) make a payment to a physician, in an amount determined in accordance with the regulations, whether the physician submits accounts directly to the plan under section 15 or not; and

"(c) increase, by an amount determined in accordance with the regulations, a payment to a physician, whether the physician submits accounts directly to the plan under section 15 or not.

"Health Care Accessibility Act

"(2) If a payment decreased under clause (1)(a) was wholly or partly for an insured service rendered by a physician who does not submit accounts directly to the plan under section 15, for the purposes of the Health Care Accessibility Act the amount payable under the plan for the service shall be deemed to have been reduced by an amount determined in accordance with the regulations.

"Other agreements

"(3) If an agreement between Her Majesty in right of Ontario, or the minister, and a prescribed association or other entity representing practitioners or health facilities so provides, subsections (1) and (2), clauses 45(1.1)(k) and (l) and subsections 45(6) and (7) apply, with necessary modifications, with respect to the practitioners or health facilities."

The purpose of this amendment is to provide greater flexibility with respect to the manner in which payments are made to physicians in accordance with any agreement that may be made between the minister and the Ontario Medical Association in future.



**Mr Jim Wilson:** I appreciate the parliamentary assistant's brief comment and I would ask a question. Perhaps it's a clarification of what was raised in the House yesterday by the leader of the Ontario PC Party, Mike Harris, and of course contained in the media over the last few days. That's how physicians are dealing with the social contract imposed on them by the government. It worries me to read the OMA press release and subsequent media reports in which it's contended that there will be some nine days taken off each of the next three years by physicians, ie, there will be days where physicians will not be providing services to their patients.

I would ask the parliamentary assistant to update the committee with respect to this matter.

**Mr Wessenger:** I think it's fair to say that this provision is not in any way put forward to deal with that particular suggestion with respect to the proposal put forward by the OMA; it's really to deal with the matter of whether there are any proposals put forward for differential payments. We expect there may be. There may be different classes of physicians who the OMA may decide should be dealt with differently than other classes of physicians, and I'm assured that will probably be dealt with by the joint management committee in any future negotiations.

**Mr Jim Wilson:** I raise the matter at this point because in my opinion it does deal in a general way with this section. That is, the government motion, as does the PC motion that's been stood down, does allow for flexibility in payments. To me, that allows for flexibility in meeting social contract obligations. It worries me, although obviously the wording of this particular amendment doesn't talk about days off or provisions of the social contract. I would like that cleared up.

**Mr Wessenger:** I think it should be made very clear that nothing would be done without the agreement between both the government and the OMA with respect to the matter of how payments are dealt with. That requires agreement on both sides. I can assure you that the government would not do anything that would compromise the delivery of medical care in the province of Ontario.

**Mr Jim Wilson:** I want to say for the record that I agree with the government's motion. I think it's similar to the motion that was put forward by my colleague Mrs Cunningham yesterday. I give credit to my party, I suppose, for flagging this issue for the committee and I'm glad to see the government has responded.

I would ask the parliamentary assistant, because I don't want to leave the topic without clearing the air a little bit, with respect to social contract obligations, payments to physicians, it's my understanding that with this amendment the OMA would no longer be tied into simply a 4.8% cut across the board and that this amendment would allow greater flexibility in future negotiations.

**Mr Wessenger:** I think it's basically to say that unless there's an agreement, the 4.8% cut across the board would apply. It would require the agreement of the government and the OMA to modify that position.

**Mr Jim Wilson:** I appreciate and expected that

response. Therefore, I would ask you, what time frame are you looking at with respect to agreement in this area between the government and the OMA given that it's my understanding you've missed just about every other time line that was suggested in the interim economic agreement between the government and the OMA?

**Mr Wessenger:** Perhaps to clarify this, I don't really see this as something of an immediate time frame situation. I see this as something that can apply well into the future and several years down the road. As circumstances change with respect to the delivery of medical care in the province of Ontario, there may be new arrangements that have to be negotiated, and this legislation provides the flexibility for making those new arrangements.

I don't see this amendment as particularly with respect to the aspect of the social contract but as a longer-term approach to give the government the flexibility to deal with differing payment mechanisms than it now has. In other words, we're limited at the moment to a fairly crude measure of dealing with payments to physicians, and if we continue down the road of other agreements with other health professions, as well as future agreements with the OMA, this will provide that flexibility in entering into those agreements.

**Mr Jim Wilson:** To follow up on this, I think it is important that we again try to clear the air. I'm giving the government ample opportunity here in a very peaceful fashion to alleviate some of the concerns of the public with respect to what's been in the media recently; that is, the social contract or Rae days that physicians may take off and not provide services on. Physicians feel they're in a bit of a box with respect to this issue. The only time I have to discuss it with respect to this bill, I think, is most appropriate with this amendment. What options are being currently reviewed between the government and the OMA with respect to the social contract or the 1993 interim economic agreement?

**Mr Wessenger:** As far as I know, I don't think that really we've had any negotiations on this particular aspect at this time. This was seen by the minister as a way of providing for flexibility within the legislation. If you're asking with respect to the particular issue of the days off, I don't think that proposal is a particular one that is likely to be implemented. I think that's all I can say.

**Mr Randy R. Hope (Chatham-Kent):** I wasn't going to embark on this conversation, but the same people who have spent millions of dollars campaigning against this government, saying we're going to destroy the health care system, are talking about every doctor taking nine days off at the same time. I wasn't going to embark on this conversation until it was brought up. I find it very ironic that the same people who campaigned and spent millions of dollars against this government around the social contract have the audacity to put across nine days, saying they all want to take the days off.

I hope the minister would never ever consider that, because there are a lot of people in this world today who are working under a social contract who are not taking days off and who are directly affected by a wage reduction. For the medical profession to publicly state taking those days off altogether, I find that very ironic, especial-

ly in the depths of the campaign it levelled against the government about trying to destroy the health care system and then counteracting that with those days off. I just hope the minister never ever considers that because this member won't accept that as a term of reference for the citizens I represent.

1640

**Mrs Sullivan:** I think we should look at why this amendment is here. It's here because the government, under the expenditure control plan, has asked physicians to reduce the cost of their services by \$275 million and, under the social contract, to reduce the cost of their services by \$200 million.

The framework agreement which was introduced in 1991 brought in thresholds, and there was an agreement that those thresholds would be applied at certain levels of physician income. It appears that there was no legislative authority for those thresholds to exist. Now we are further down the road and a new kind of threshold is being looked at involving a new pressure, and that new pressure is the expenditure cuts and the social contract.

What the OMA has had to do is to balance how the new pressure can be implemented, given the surround of the agreement it signed with the government. The OMA put forward several options to its membership in various regional and other ways and discussions were held across the province. It appeared that for many of those options there was not the legislative authority for implementation, and that's why this amendment is here.

During our public hearings we talked about, and in fact I can recall asking questions with respect to how, if there were certain steps taken to ensure that the 4.8% clawback was implemented, there would not be a kind of arbitrary stance about where one started in terms of being judged.

The female doctor who has taken time off her practice and therefore hasn't billed while she's having a baby and taking some time in a new family situation is one example. Physicians who have been practising in a locum situation and not using their own billing number are another example. It appears, however, that the OMA has made a decision about how it sees, most effectively within that particular profession, meeting the demands that are being made in terms of service reductions and that a vote has been taken to implement unpaid days for each of the three years of the social contract. These were not the only options, however, that were presented, and whether this is the final option the OMA will come to or not is another story.

I have certainly had calls from individual physicians. God knows there are 23,000 doctors in Ontario, and I have not had calls from them all, but many of them are very concerned at some of the options that were put to them and what decision-making will be done by their representatives that may affect their particular sectors within the medical association.

As far as I'm concerned, the OMA has come forward with this amendment as an executive body. They have made that recommendation to government, and whether an across-the-board equivalent treatment of all doctors is a preferable option or whether there is another option

that's available, it seems to me there has to be legislative authority to do what wasn't done in the 1991 agreement. I suppose this amendment provides flexibility to take into account this arrangement.

I was surprised, I have to suggest, that in the options that I see—and there may be more; maybe I didn't get all the pages—one of the options that wasn't put was the option that is already authorized legislatively, and that is a cut in the fees under the fee-for-service schedule.

Maybe that's there, maybe that has been on the table, maybe it won't work and maybe they can't reach their targets. I think this is a hell of a way to plan a health care system.

**Mr Jim Wilson:** Just very briefly, somewhat in response to Mr Hope's comments, I just want to read a paragraph out of the *Globe and Mail* dated November 15. It says:

"OMA president Dr Tom Dickson told a press conference Saturday that physicians want to be treated like all other members of the public service. 'We can either take a reduced price per service or we can try to reduce the number of actual services. Nobody else under the social contract has been asked to take a reduced price. They have been asked and ordered to take days off, in other words, reduced service. That's exactly what we're trying to do.'"

I hope, Mr Hope, that you'll take Mr Dickson's concerns into consideration, that the government will do so. I think the physicians have been forced into a rather uncomfortable corner by this government, and it'll be interesting to see what the government's response is.

Again, I would ask the parliamentary assistant for a time line with respect to those negotiations.

**The Vice-Chair:** Do you wish to respond, Mr Wessenger?

**Mr Wessenger:** No, I don't wish to respond. But I think, just to reiterate the aspect we have to look at, we're in a new world with respect to our health, payment for health services. We've moved away from an open-ended insurance model to a management model. In a management model with overall caps on health-care spending, which I think are here to stay permanently, you have to have the flexibility to deal with those caps. I think this motion provides that flexibility to deal with that.

**The Vice-Chair:** Any further discussion? If not, a vote on Mr Wessenger's motion. In favour? Opposed? Carried.

Would you proceed with the next amendment, Mr Wessenger.

**Mr Wessenger:** I move that subsections 2(4), (5) and (6) of the bill be struck out and the following substituted:

"(4) Subsection 45(1) of the act is amended by renumbering clause (a) as clause (a.1) and adding the following clauses:

"(a) prescribing the form of the health card;...

"(c.1) prescribing numbers of members for the purposes of clauses 5(2)(a) and (b) and paragraphs 1 to 5 of subsection 6(1);...



"(w) prescribing persons for the purpose of subsection 11.1(2);

"(x) prescribing, for the purpose of clause 19.1(3)(d), what constitutes an application for a provider number or its equivalent;

"(y) prescribing persons for the purpose of subsection 43.1(1)."

Before I continue, I'd like to ask legislative counsel about clause (a), where it says "prescribing the form of the health card." "Health card" is defined. Okay?

**Mr Frank Williams:** That's right.

1650

**Mr Wessinger:** Okay. If I might continue then,

"(5) Section 45 of the act is amended by adding the following subsections:

"Regulations to implement agreement

"(1.1) In order to implement an agreement that deals with a matter referred to in this subsection and that is made, after the coming into force of subsection 2(5) of the Expenditure Control Plan Statute Law Amendment Act, 1993, by the government of Ontario (or the Minister of Health) and the Ontario Medical Association, the Lieutenant Governor in Council may make regulations,

"(a) prescribing, for the purpose of clause 19.1(3)(g), classes of physicians that are eligible for the purpose of section 19.1;

"(b) prescribing the classes of physicians that are not eligible under section 19.1(4);

"(c) prescribing, for the purpose of clause 19.1(7)(b), the purposes for which the minister may exempt a physician or a class of physicians from the application of subsection 19.1(1);

"(d) prescribing services that meet the requirements of clauses 36.1(1)(a) and (b) as third-party services, or prescribing them as third-party services in specified circumstances, and specifying the circumstances;

"(e) in relation to a specified third-party service or in relation to a third-party service provided in specified circumstances,

"(i) prescribing another person or entity as a third party instead of or in addition to the person or entity who makes the request or requirement referred to in clause 36.1(1)(a),

"(ii) if more than one person or entity make the request or requirement referred to in clause 36.1(1)(a), prescribing one or more of them as third parties and providing that the others are not third parties, or

"(iii) providing that there is no third party;

"(f) designating or establishing a body that shall have power to decide disputes about payment for third-party services, including power to summon witnesses and require the production of documents and power to award costs and interest;

"(g) governing the composition of the body referred to in clause (f), the qualifications, appointment, functions and remuneration of its members and their immunity from liability;

"(h) prescribing the parties to a proceeding before the

body referred to in clause (f) and the rules governing practice, procedure and evidence in a proceeding before the body, including prescribing whether or not the body is required to hold a hearing;

"(i) prescribing the duties and powers of the body referred to in clause (f) in relation to making decisions and orders;

"(j) providing that a court or body acting under subsection 36.3(4) shall consider other matters in addition to or instead of the guidelines and schedules of fees referred to in subsections 36.3(5) and (6), and specifying those other matters;

"(k) prescribing amounts for the purpose of clauses 26.1(1)(a), (b) and (c), or prescribing rules for determining those amounts;

"(l) prescribing amounts for the purpose of subsection 26.1(2), or prescribing rules for determining those amounts;

"(m) prescribing associations and other entities representing practitioners or health facilities for the purpose of subsection 26.1(3).

"Classes of physician

"(6) A regulation made under clause (1.1)(k) may prescribe different amounts or rules for different classes of physicians, and for that purpose may prescribe classes of physicians.

"Nil amount

"(7) An amount prescribed under clause (1.1)(k) or determined according to rules prescribed under that clause may be a nil amount.

"(6) The act is amended by adding the following section:

"No appeal

"45.1(1) Every decision by a body designated or established under clause 45.1(1)(f) respecting a dispute about payment for third-party services shall be final and binding and shall not be subject to appeal.

"Enforcement of decision

"(2) The body designated or established under clause 45.1(1)(f) or a party to a proceeding before the body may file a copy of the decision or order of the body, excluding the reasons, in the Ontario Court (General Division) or, if the amount ordered to be paid does not exceed the monetary jurisdiction of the Small Claims Court, in the Small Claims Court and, when so filed, the decision or order may be enforced as an order of the court in which it is filed."

This provision sets out the regulation-making powers and particularly deals with the question of setting up an alternative tribunal to the courts with respect to third-party obligations.

**Mr Jim Wilson:** Mr Chairman, could I ask for an explanation or clarification from the parliamentary assistant and perhaps legal counsel? I understand this is version 3 of this particular government motion. What makes it different from the previous version that was provided to us earlier by the government?

**Mr Wessinger:** I'll ask legal counsel to cover that.



**Mr Williams:** The simple explanation is that we had provided for every permutation and combination of the different versions of the health card reporting section and whether or not things could or could not be ruled out of order. This is the version that best matches what has happened this afternoon.

**Mr Jim Wilson:** You're asking for a great deal of power here with respect to the powers of the Lieutenant Governor in Council, ie, cabinet.

**Mr Wessenger:** It's all complementary to everything we've passed, Mr Wilson.

**Mr Jim Wilson:** I suppose I'm to take your word for it.

**Mr Wessenger:** Well, I'm taking legal counsel's word for it.

**Mr Jim Wilson:** We've been down this road before, Mr Wessenger.

**Mr Wessenger:** I can usually rely on legal counsel.

**The Vice-Chair:** Any further discussion?

**Mr Jim Wilson:** Could we just have one minute, Mr Chairman? It is a lengthy motion that hadn't been seen previously. Perhaps it would be useful if the parliamentary assistant or legal counsel could just take us through the steps that would be encountered with respect to third-party billings in terms of the body that's to be set up to enforce decisions with respect to that issue. Give us a layman's road map.

**Mr Wessenger:** I'll ask legal counsel to see if they can summarize basically what the provisions provide with respect to third-party tribunals. Is that correct?

**Mr Jim Wilson:** Yes.

**Mr Williams:** Bear with me if I go through this slowly to make sure I'm not missing anything.

If you go to clause (e), I think that's the first clause that addresses the issue you've asked about. Clause (e) prescribes the power to name another person or entity as a third party; then (f) goes on to establish or designate the body that you've now referred to; (g) talks about the composition of that body, qualifications of appointment, functions and remuneration of the members and their immunity from liability; (h) is prescribing the parties to a proceeding before that body; and (i) the duties and powers of the body itself.

**Mr Jim Wilson:** Yes, but what I'm interested in is, because these are regulatory powers, there's not much meat on the bones here. I really can't envision exactly how the body will function. Is there even a title attached to this body?

**Mr Williams:** This would be a body that would be negotiated between us and the Ontario Medical Association as being the appropriate body. It would function similarly to a court except that we envision that rather than getting into a lengthy tribunal type of hearing, there could be an exchange of documents to eliminate the problem that people have when they go before tribunals and courts and have an exchange of documents a paper hearing.

**Mr Jim Wilson:** This particular body, though, is it envisioned that it would consist of prescribers and

government members?

**Mr Williams:** We haven't decided, but it could be a mix of all of the above, none of the above, whatever we agree would be the appropriate mix in the circumstances.

**Mr Jim Wilson:** Its decision is final according to this?

**Mr Williams:** Yes. We don't anticipate, quite honestly, that there'd be a large volume of cases that would come before this tribunal. The more likely scenario would be that there might be a flurry at the beginning, and once there's a precedent-setting case or two, things will resolve themselves between doctors and third-party requesters.

**Mr Jim Wilson:** Correct me if I'm wrong. What I'm driving at here is that we had representations from school board authorities and from the hospital association with respect to, in some cases, who would pay for services that had been delisted; ie, if a service had been delisted but it was normally performed in a hospital, the act, as previously written, certainly made it clear that physicians would be reimbursed. A dispute regarding a hospital that may feel it hasn't been properly reimbursed for a service conducted within its walls, would it go before this body? That's what I'm trying to envision here.

1700

**Mr Wessenger:** I don't think it was likely envisioned you're going to have the problem with a health facility or this type of third-party situation. I'm sure that would be resolved. I would think it would more likely apply to somebody who had been billed excessively, basically. An individual objecting to being billed excessively is most likely where it's going to arise.

**Mr Jim Wilson:** So a consumer could make a complaint—

**Mr Wessenger:** A consumer, that's right. I can see this tribunal being basically consumer oriented and not being related to the institutions. They would generally all be dealt with in advance. Just talking from a legal practice point of view, normally these issues are resolved well in advance. When it's institution dealing with institution or business dealing with medical practitioners, you don't generally have a problem under our existing situation. Where the disputes arise is when a consumer feels they've been overcharged.

**Mr Jim Wilson:** I'm still concerned, though, with some of the comments made by day care operators, school boards and hospital associations because the way I read this—and I may have missed something yesterday so please correct me—is you could be trapping some institutions, for example, because this is their only recourse. Say, as you say, Mr Wessenger, that a particular billing wasn't resolved ahead of time, this to me reads that persons or entities no longer have the right to go to court, but are into this tribunal process. I'm trying to think of the worst-case scenario obviously.

**Mr Wessenger:** If I might sort of indicate, remember that the third parties who are going to be liable are those who are prescribed under the regulations.

**Mr Jim Wilson:** But having not seen the regulations, it makes it difficult.

**Mr Wessenger:** Of course, there is a review going on

with respect to the question of—many of these issues may be resolved away from the third-party issue. That's what probably I'd like to indicate, that when the review is conducted, I suspect the issue with respect to an institution such as a school or something would be dealt with in an alternative method rather than under this method.

**Mr Jim Wilson:** Okay. I don't want to prolong the point, but you're asking for some pretty wild, far-reaching powers and you're not giving legislators much of a vision on what exactly we're voting on with respect to this amendment. I'm trying to get it out of you the best I can.

**Mr Wessinger:** You should remember that all the body is determining is whether the charge was reasonable. Isn't that correct?

**The Vice-Chair:** Plus the right to recover when—

**Mr Jim Wilson:** Except that, through regulation, you could expand those powers, could you not? The way this is written, you're not just limited to what you just said.

**Mr Wessinger:** I think when you're setting up a tribunal, you'd have to—I would ask legal counsel to confirm this is a usual provision—

**Mr Jim Wilson:** The record of setting up tribunals in this province is dismal. I'm about to vote on setting up another one and I'd like to know exactly what it's supposed to be doing.

**Mr Wessinger:** It would be parallel to a court basically. A tribunal could do exactly the same as a Small Claims Court would decide. I understand the concept here is to have a tribunal rather than the court because it felt it could be done purely on a paper basis, have summary procedures and be less expensive and less cumbersome for those people dealing with the issue, because I think it's fair to say that both consumers and providers find the courts somewhat of a cumbersome process to work with.

**Mr Jim Wilson:** I appreciate that point, but I think this shouldn't be lost on committee members. This is a very important tribunal in terms of if the government's going to continue to delist services, contrary to what legal counsel's opinion was, my political opinion would be that this could be a very busy body indeed. I would have preferred that we had a little more information with respect to where the government's going on this. None the less, Mr Chairman, I don't expect I'm going to get those answers tonight.

**Mrs Sullivan:** I want to move to a different section of the regs with respect to classes of physicians. You will recall that in the original Bill 50 one of the major points of contention was with respect to the minister unilaterally having the power by regulation to determine classes of physicians and different amounts by which the physician would be reimbursed and different rules would be put into place for different classes of physicians.

As I recall the debate at the time of the bill, one of the organizations that was most strongly opposed, among others, to that provision in the original bill was the Ontario Medical Association.

We see that the regulations would now allow the minister to prescribe precisely those things which were

most highly objected to when the bill was first brought forward: different classes of physicians, different rules with no explanation of what those rules are, whether they're with respect to geography, whether they're with respect to types of service provided, whether they're with respect to numbers of patients that may be seen, how frequently. "Rules" is a very generic word. In fact, rules may encompass every single feature of the original Bill 50 which was supposed to have been gutted by these recent amendments.

I suggest to you that there haven't been any wins with this legislation.

**Mr Wessinger:** Legal counsel may want to add something, but prescribing obviously is in accordance with the provisions of the act. You can't go beyond prescribing classes of physicians for anything outside the scope of the act. So it's limited to that extent.

**Mrs Sullivan:** The scope of the act, I suggest to you, now includes quite extraordinary flexibility with respect to compensation for professional services and that flexibility, when such a generic word as "rules" is used, could mean the very things which we objected to and which I believe will destroy medicare in Ontario.

**Mr Wessinger:** I would point out that the prescribing classes would only be on the agreement with the OMA. Remember that clause is only with respect to implementing the provisions of an agreement.

**Mrs Sullivan:** No, that's incorrect. This refers right back to 45(1), to the regulations under the existing act. There is no indication that regulations under the existing Health Insurance Act require the consent of the Ontario Medical Association.

**Mr Wessinger:** Which provision are you particularly referring to?

**Mrs Sullivan:** Page 3, classes of physicians. This is a new regulation adding to subsection 45(1) of the existing act.

**Mr Wessinger:** Yes. If we go back to (1.1), it says, "Regulations to implement agreement: In order to implement an agreement that deals with a matter referred to in this subsection and that is made after the coming into force of subsection 2(5) of the Expenditure Control Plan Statute Law Amendment Act." So all this regulation-making power is limited to implementing an agreement.

**Mrs Sullivan:** In which case that agreement may well, without discussion, change the face of medicare. In this case, there are two partners attached to the decision-making.

**Mr Wessinger:** I think if an agreement is entered into between the government and the OMA, they have the power under this to implement the revisions of any such agreement.

1710

**Mr Robert Frankford (Scarborough East):** I'm not a regular member of this committee so excuse me if I'm off on a tangent, but I was intrigued by a question which Mr Wilson was asking about the third-party situation.

I just wondered whether there might be circumstances in which the ministry or OHIP would find itself, as the



third party, let's say in relation to procedures around the margin of what's eligible or not. I'm thinking perhaps of dental or facial things which I think often get into a rather marginal area of eligibility. Would that perhaps be a situation in which, as Mr Wilson says, there would be appeals because of the rather broad area that this body would be looking at?

**Mr Wessenger:** We do have a health services appeal which I believe would deal with a lot of those issues which you're concerned about, Dr Frankford, but I'm advised by legal counsel that the Health Services Appeal Board would be the body that would deal with those issues.

**Mr Jim Wilson:** What worries me about this whole thing, and I think Mrs Sullivan touched on it briefly, goes back to some of the discussion we had during the public hearings.

Basically, when this act passes and particularly these classes of physicians and some of the other provisions referred to, particularly (k), "prescribing amounts for the purpose of clauses" etc, if the OMA and the government want to continue to conspire to set up a two-tier medical system within the province of Ontario, we're giving you legislative authority to do that. Where is the public input for what's going on here with respect to classes of physicians, different amounts assigned to different physicians?

I raised, during committee hearings, what about those physicians who specialize in completely delisted services? Dr Tom Dickson of the OMA sort of didn't want to touch that one and I couldn't get any response from the government either, but you're asking for incredibly sweeping powers. You're counting on the fact that all future agreements are between the OMA and the government and behind closed doors you're going to do all this. I would have thought at least we'd have an explanation from the government with respect to public input.

I know now in a token way you're giving some public input with respect to delistings, but you are changing the way physicians traditionally have been reimbursed by the province, you possibly could change the classes of physicians that we have, yet a lot of this wasn't discussed thoroughly in the public hearings with respect to this bill and that disturbs me greatly.

I think you're slipping through some pretty powerful legislation in the hope that the public doesn't catch on. It's my belief that the public will only catch on when problems start to occur long after you people are out of office.

**Mr Wessenger:** The only thing I might point out is that section 26.1 relates purely to the question of how payments are made to physicians. That is what it is limited to, the question of payment to physicians only.

**Mrs Sullivan:** And may include zero payment, which may include zero service whether it's medically necessary or not.

**Mr Wessenger:** We certainly have political accountability. That's the way our system works.

**Mrs Sullivan:** I have one other question and I had forgotten to ask it when Mr Wilson was leading the

discussion on the third-party services. Could the parliamentary assistant tell us what fee schedules exist now for services which are not insured, how are they made public, will this new body have access to such a fee schedule and how will that be negotiated? What is the fee schedule and how is it determined for those services not considered to be insured services? Who makes that decision?

**Mr Wessenger:** Who makes the decision? Obviously, the question of what items are insured is made by whatever government happens to be in power. One of the problems with respect to the fee schedule is that it's sort of grown over the years and never really been looked at to determine what is appropriate and what is inappropriate. There may be a lot of areas in the fee schedule that—there's historical growth, so it may need a fair amount of rationalization. That's certainly what the joint management committee is designed to look at, to ensure that appropriate medical care is delivered.

That will continue to be an ongoing process. I think we will always be in an ongoing process of looking at schedule benefits to determine what is appropriate and what is not appropriate to be covered.

**Mrs Sullivan:** That isn't my question. We have new regulations that were brought forward, effective January 1, which delisted many services which in fact had not been, I acknowledge, really an essential part of medicare in that there could have been arguments made that they were not medically necessary and not part of a course of treatment. None the less, traditionally those services had been covered by OHIP, and it was a tradition that had built up over many years. The liability for payment for those services will now be a liability on a third party.

You have set up, or you will be setting up, a body with respect to disputes about where the bills go and who should pay and so on. What I'm asking about is, who sets the schedule, who determines how much those services cost and who will make a judgement about the cost of those services?

Is that a function of the new body? Is that a function of the OMA? Is it a function of the individual doctor, who says that, say, for a return-to-work physical it will cost \$80 or it will cost \$500 or whatever they're going to charge? I understand the college's role in terms of dispute resolution if a practice is considered to be unprofessional, but who would be setting the schedule, the fees, the price list for those services, which are now by regulation deinsured and will be charged for?

**Mr Wessenger:** I'm uncertain whether you're referring to the third-party issue of services or whether you're referring to the broader question of the situation with respect to medical services in general. If we're dealing with the third-party situation, the first thing I'd like to indicate is that there has been no basic change since 1980 with respect to the question of which third-party items are not insured.

In 1980, under regulation 452 of the Health Insurance Act, there were certain services which were deemed to be uninsured. Some of them were medical examinations, for instance, for the purpose of an application for admission to or continuance at a school, college, university, camp, association, club, group or program.



**Mrs Sullivan:** I understand all that. What I'm saying is, who sets how much those services cost?

**Mr Wessinger:** I understand for third party, the Ontario Medical Association has a schedule, and the Colleges of Physicians and Surgeons oversees that the fees set out in that schedule are not excessive. In effect, the OMA would set a suggested fee schedule and the college, as the governing body, has the obligation to see that what the OMA does is not excessive.

**Mrs Sullivan:** Would this body that you're setting up be dealing with disputes with respect to the cost that's charged by a physician for a service which is not insured? Is that part of the mandate?

**Mr Wessinger:** We're talking about under the bill?  
1720

**Mrs Sullivan:** Yes, under your regs, the new body that you're setting up to deal with disputes as to who pays for third-party services.

**Mr Wessinger:** Counsel's gone, but my understanding would be that this only deals with the third-party issues; that is, where there is not—

**Mrs Sullivan:** But that's going to be the question. If I am a school board and parents of children—no, just a minute now. I am an insurance company; I represent an insurance company.

**Mr Wessinger:** Okay. That would be better than saying—

**Mrs Sullivan:** A person who is applying for continuation of insurance and has to have a document with respect to that application goes to the doctor. That will now be a third-party billing. It is required by the third party, me, the insurance company. I get the bill. I don't want to pay the bill. The patient I have sent there is ultimately asking me to appear before the new body you're setting up. The new body you're setting up has a mandate. The reason I don't want to pay the bill is that I think the bill is excessive. Does the new body you're setting up deal with the cost of the service or simply who is liable for payment?

**Mr Wessinger:** No, I understand the tribunal has the right, if it feels the fee is excessive, to reduce it. It will definitely have the jurisdiction to reduce an excessive fee.

**Mrs Sullivan:** In general, will the body be responsible, then, for a kind of negotiating role with the OMA with respect to those third-party services which are not insured?

**Mr Wessinger:** No, the tribunal will not be responsible for any negotiating. It's purely a hearing body only.

**Mr Frankford:** I just wanted to hopefully be helpful in clarifying this. To my understanding, the OMA has always published, way beyond the inception of medicare, a recommended tariff for procedures of all sorts and I think has recommended for everything conceivable, including things like certification. In some things it's just been able to put in a suggested range; things like legal reports, obviously, the range of what one should charge can vary enormously. I think conceivably there would be disputes about how physicians choose to interpret the range that the OMA would recommend. I would imagine

that in most cases, the tariff, the fee, is something which could be found by reference to the OMA. As I understand it, this body would be more looking at whether there's liability and who the third party is that has that liability.

**Mr Wessinger:** Yes, the body would look at the tariffs as a guideline, but it isn't binding on the body.

**Mr Jim Wilson:** I never did get an answer from the parliamentary assistant with respect to public input. It seems to me there's been a lot happen with respect to directing the health care system over the last couple of years. I think a pivotal point was when the government unionized the physicians of this province last year. Now we have a health care system for which I see the public having very little input on its future direction, and I'd like to know from the parliamentary assistant how or when the conscious decision was taken that all health care direction in this province with respect to insured medical services in the future will strictly be between the union and the government and that the—

*Interjection.*

**Mr Wessinger:** No.

**Mr Jim Wilson:** Well, you know, the powers you're asking for in this act go beyond what we traditionally asked, what we traditionally looked for, in OMA-government agreements. You unionized the physicians, which a lot of them still don't realize in this province, then you hash out this thing, all in the name of economics. It has a lot less to do with economics—when one looks at all the cabinet authority that's being requested in this bill, it's got more to do with the future direction of our health care system.

I want to know, as a legislator, how are my constituents supposed to be involved in this? What is the avenue for the average person? I can see, after this bill is passed, I'll have the constituents, down the road, perhaps in a few months and a few years, complaining about different aspects of the health care system, that it's not meeting their needs. As some government member heckled a few minutes ago, we'll send them to the OMA.

It seems to me that you've closed the system. It's strictly between the government and the OMA now. We've got other health care practitioners shut out of the system, whether they realize it now or not. When this passes, what do you say? What are you going to say to your constituents, Mr Wessinger? You don't have any authority any more, unless you happen to be in cabinet.

**Mr Wessinger:** First of all, I think the whole issue of public participation is not really relevant, in my opinion, to Bill 50. Bill 50 is implementing agreement.

**Mr Jim Wilson:** It's relevant to every piece of legislation, including this one.

**Mr Wessinger:** If I might just continue, since we invited a philosophical discussion today, I think we could all, if that's what we'd like to indulge in—

**Mr Jim Wilson:** A philosophical discussion is necessary when one has a bunch of—

**Mr Hope:** I'd like to stick specifically to the amendment which we're dealing with and not to a philosophical viewpoint.

**Mr Jim Wilson:** We are. These regulations cover anything you want to bring up.

**The Vice-Chair:** Please, one speaker. Mr Hope, continue.

**Mr Hope:** I'd like to make sure that we stick with the amendment, not the philosophical viewpoints.

**Mr Jim Wilson:** This isn't philosophical. What are you going to tell your constituents? They're struck right out.

**The Vice-Chair:** Mr Wessinger has the microphone.

**Mr Wessinger:** I'm going to respond philosophically and practically to the fact that in the past we've had the schedule of benefits determined solely by the OMA. Purely, the OMA in the past has determined what benefits were under the health insurance schedule.

We have moved now to a situation where we're having public participation with respect to the schedule of benefits. This is not related to this legislation, but the aspect is that there is now a public participation process. As I think was indicated many times previously in this hearing, we now have the public being part of determining what should be appropriate medical care. I would hope to see that expanded. I think this is the beginning, and I would agree we have to go much further. I would hope that we will move much further towards having public participation on the whole question of what appropriate medical care is.

**Mrs Sullivan:** I don't know if the government understands how offended we in our party and others feel about the bilateral nature of the determination of the shape of our medicare system. If the government party doesn't understand that this is part and parcel—

**Mr Hope:** Mr Chair, on a point of order: Are we sticking with the amendment that's being put forward—

**Mrs Sullivan:** You're darn right I am.

**Mr Hope:** —or is this a philosophical viewpoint again?

**Mrs Sullivan:** You're darn right I am.

**The Vice-Chair:** Please. Did you complete your point of order?

**Mr Hope:** I'd like to stick to the amendment that's been put forward instead of the philosophical viewpoints that are being expressed.

**Mrs Sullivan:** I'm speaking precisely to the regulations that will give enormous bilateral power. They are there. Just look at the regulations.

When the parliamentary assistant suggests that the new process with respect to changes to the schedule of benefits involves the public, let me tell you that if it's not misleading the public, it comes very close. The agreement says:

"The government shall within 30 days of ratification" of the agreement "suggest a list of services to the JMC that could be delisted from the schedule...in an amount not less than \$20 million.

"A panel appointed by the JMC...comprised of two physicians, two members of the public and two government members, with an independent chair, shall review

the recommendations for delisting and make recommendations to the JMC on a package of services that could be delisted in the amount of \$20 million within 90 days of ratification."

Don't tell me this is a public process.

1730

Secondly, the regulations under this bill and the bill itself are there for one purpose and one purpose only: to come to terms with the agreement that has been reached between the government and the OMA. My personal view and that of my party is that bilateral agreements should not be directing the future of medicare in Ontario.

**The Vice-Chair:** Do you wish to quickly respond?

**Mr Wessinger:** I'll just make one comment. One aspect was neglected. I understand, and it's been clearly indicated, that the public will have the right to make representation to this panel. If that's not public participation, I don't know what it is.

**The Vice-Chair:** Shall Mr Wessinger's motion carry? Carried.

Mr Wilson, are you in agreement that the previous proposed amendment, the PC motion presented by Mrs Cunningham, be withdrawn?

**Mr Jim Wilson:** We'll be withdrawing that motion, which for the record is the motion dealing with subsection 2(3.1).

**The Vice-Chair:** That's correct. That is withdrawn.

Shall section 2, as amended, carry? Carried.

Shall section 3 carry? Carried.

Shall section 4 carry? Carried.

Section 5, the short title: I believe there's an amendment to that.

**Mr Wessinger:** No, there's no amendment to the title. It's not necessary.

**The Vice-Chair:** No amendment necessary?

**Mr Wessinger:** No.

**The Vice-Chair:** Shall section 5, the short title, carry? Carried.

Shall the long title of the bill carry? Carried.

Shall I report Bill 50, as amended, to the House? Agreed.

#### SUBCOMMITTEE REPORT

**The Vice-Chair:** Item 2 is report of the subcommittee on committee business. I believe you have received a handout from the clerk regarding this matter. Any questions regarding the report of the subcommittee on committee business dated Thursday, November 4, 1993?

**Mr Jim Wilson:** I believe the report of the subcommittee is an accurate account of what occurred at the subcommittee. It's my understanding, although I'm not clear, that the House leaders are not likely to come to a unanimous agreement with respect to the issue of night sittings for Bill 100. I think it's appropriate to raise that at this time. I'd like to put the government members on notice that more regularly scheduled committee hearings are going to be required. There is no precedent for night sittings, and I don't think we're going to get agreement; the two opposition parties are having difficulty with that.



We have all kinds of legitimate reasons.

Secondly, there will not be enough time in the schedule to hear all of the witnesses. The government caucus should go back and consider either doing something to extend these sittings within normal sitting days or sitting again in January on Bill 100.

To be fair to all of the people who are asking to appear before the committee, I don't think Bill 100 can reasonably be done within the dictated time lines as put forward to us by the NDP. I want that clearly on the record. There are a lot of things happening in health care and, unfortunately, Bill 100 has been given very, very few public hearing days. The government's going to have to consider adding some more public hearing days during regular committee meetings.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I heard a statement that there's no precedent for night sittings. I don't think that's accurate. We've sat for extraordinary bills or motions or presentations. We've sat for teachers' pensions. We've sat for constitutional hearings. Last year we sat for MVA, which was a very local issue. So to say that this issue is dead and that we can't proceed to ask our House leaders to continue to negotiate on this item at this particular date, to me, is unacceptable.

**Mr Larry O'Connor (Durham-York):** We certainly do have a list of people who would like to come before us and I'm hoping that the House leaders—maybe the House leader's office is watching us now. We certainly do have a concern. We'd like to be sitting in the evenings to fulfil the wishes of as many people who want to present as possible. So I support the subcommittee report and hope that all the House leaders can sit down and come with an agreement on these sitting days. Perhaps we can sit in the evening to deal with the public hearings aspect of this, because it is an important piece of legislation.

**The Vice-Chair:** You're prepared to move the adoption of the report?

**Mr O'Connor:** I'm prepared to move the adoption of the subcommittee report.

**Mrs Sullivan:** The subcommittee has advised that it has directed the Chair of the committee to write to the House leaders making the request. I believe that would have been done before this meeting, so as a consequence that action has been taken. I understand that a decision

either has been made or is imminent that there will be no night sittings, so we will have to then adjust our schedules accordingly.

**The Vice-Chair:** We don't have the decision itself, though.

**Mrs Sullivan:** No, but I think it may just be something to keep in mind.

**Mr Jim Wilson:** I know we don't have the decision, but the subcommittee meeting was on November 4 and a lot of discussions have occurred since then. Just because we're adopting it now doesn't mean that life stood still waiting for us to adopt this subcommittee report.

Back to my point about precedents: I don't think there have been precedents given for what we're requesting, and that is a blanket authority to sit nights across the board. There have been exceptions, yes, for committees to sit during the evening, but it's the fact that I think Ms Sullivan's correct. I do not think the House leaders are going to agree on blanket authority to sit evenings. We frankly raised this as part of this discussion on the report so that the government might, rather than waste any time, get back to us as soon as possible and indicate what the response will be to this issue.

These are going to be, I think, very emotional public hearings, very difficult hearings for a number of people, and I think the government is going to have to consider, during normal legislative time, extending these hearings at least further into December, if the House is sitting, and perhaps to be real and to ensure that all the witnesses are allowed to be heard, into January.

No party wants to delay this legislation. My party brought forward a private member's bill which essentially got the ball rolling on this legislation. That was a bill introduced by Mr Eves. But to be fair to presenters, I think we need a response back from the government as soon as possible.

**Mrs Sullivan:** From the House leaders.

**The Vice-Chair:** Any further speakers? If not, shall the motion to adopt the subcommittee report carry? Carried.

Any further business before the committee? If not, the meeting is adjourned.

The committee adjourned at 1739.











## CONTENTS

Tuesday 16 November 1993

<b>Expenditure Control Plan Statute Law Amendment Act, 1993, Bill 50, <i>Mrs Grier</i> / <b>Loi de 1993 modifiant les lois en ce qui concerne le Plan de contrôle des dépenses, projet de loi 50, <i>M<sup>me</sup> Grier</i></b></b>	S-507
<b>Subcommittee report</b>	S-519

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York North/-Nord L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

**\*Hope, Randy R.** (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

**\*Owens, Stephen** (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Duignan, Noel (Halton North/-Nord ND) for Mr Owens

Frankford, Robert (Scarborough East/-Est ND) for Ms Carter

Sullivan, Barbara (Halton Centre L) for Mr McGuinty

Wessenger, Paul (Simcoe Centre ND) for Mr Martin

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Wessenger, Paul, parliamentary assistant to the minister

Williams, Frank, deputy director, legal services

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Schuh, Cornelia, deputy chief, Legislative Counsel Services

C1201  
X212  
579

Document  
Publié en

S-22



S-22

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 22 November 1993

# Journal des débats (Hansard)

Lundi 22 novembre 1993

## Standing committee on social development

## Comité permanent des affaires sociales

Regulated Health Professions  
Amendment Act, 1993

Loi de 1993 modifiant la Loi  
sur les professions de la santé  
réglementées

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 22 November 1993

The committee met at 1538 in room 151.

REGULATED HEALTH PROFESSIONS  
AMENDMENT ACT, 1993

LOI DE 1993 MODIFIANT LA LOI  
SUR LES PROFESSIONS DE LA SANTÉ  
RÉGLEMENTÉES

Consideration of Bill 100, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 100, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen, and welcome to the hearings of the standing committee on social development. We're here to begin deliberations on Bill 100, An Act to amend the Regulated Health Professions Act, 1991.

The Minister of Health is with us this afternoon to make the opening presentation. Without further ado, Minister, welcome to the committee and please go ahead with your submission.

**Hon Ruth Grier (Minister of Health):** Thank you very much, Mr Chair. I'm glad to be here to make the opening statement. I very much regret that I'm not going to be able to stay for the rest of this afternoon or for all of the rest of your deliberations, but I just wanted to make the point that I consider this an extremely important set of hearings and will be following it with interest and be in close contact certainly with the government members who are members of this committee and with yourself, should that be necessary. I know lots of staff will be here to keep me up to date on what's happening.

As everyone on the committee is well aware, public concern regarding the potential for sexual abuse of patients by health professionals is unprecedented. Bill 100 is a response to these concerns and related demands for greater accountability on the part of health care professionals.

With the Regulated Health Professions Act expected to be proclaimed on December 31, 1993, it is critical that the 24 professions that will be self-regulating have a set of rules to deal with sexual abuse of patients and that patients are assured of protection against such abuse.

Sexual abuse was catapulted into public consciousness in 1991 when public hearings of the College of Physicians and Surgeons of Ontario Task Force on Sexual Abuse of Patients began. At that time, a Canada Health Monitor survey commissioned by the college indicated that almost one in 10 women in Ontario said she had been sexually harassed or abused by a physician at least once. The survey also indicated that as many as 400,000 women in Ontario may have been sexually humiliated, demeaned or violated while seeking medical care.

I'm sure everyone agrees this is an intolerable situation. Abuse of trust between a patient and a professional has devastating consequences. People need to know that the law supports their right not to be victimized. They

have the right to expect that the treatment they receive from a health care provider will be proper, not improper, and caring, not damaging.

Those of us who have never faced the trauma of sexual abuse can only imagine the extent of its damage. Survivors describe it as a devastating experience that leaves deep emotional scars. The government has a responsibility to protect the interests of the victims, to provide them with mechanisms for effective recourse and to make health professionals aware that if they abuse the relationship of trust between a patient and a health practitioner, there will be serious consequences.

The principle embodied in these amendments is clear: Sexual abuse of patients is never acceptable and will not be tolerated. It's just that simple.

Let me say that I believe the vast majority of health professionals are providing competent, prudent care. But given the extent of reported sexual abuse, it's clear that the government has an obligation to provide protection against the minority who take advantage of their patients' trust. Expedious passage of the legislation before us will address this need.

Since this legislation was tabled almost a year ago, a number of concerns have been raised with respect to the wording of some of the sections. Over the course of that year, government representatives and ministry staff have attended numerous productive meetings with interested parties to discuss possible changes to the bill, changes that will enable it to do the job we all want it to do.

I want to thank the members of the opposition parties, particularly my two critics, for their participation in the briefings and in the meetings to make this proposed legislation even better. I hope they'll agree with me that it's been a constructive use of those months.

We have listened and given serious consideration to the arguments that have been put forward. We believe that the amendments we've proposed make the legislation workable and practical and that it represents acceptable compromises. The public is eager to have these safeguards enshrined in law. The time has come to act.

Our consultations over the past year have resulted in approximately 20 amendments to the legislation. You are, I know, about to receive a detailed briefing on all of these changes later this afternoon. For now, I thought what might be helpful for me to do would be to highlight some key areas where amendments have been made in response to concerns voiced by either the public or the professionals.

As you know, the act provides for one level of sexual offence. This offence, called sexual abuse, will cover sexual relations, touching of a sexual nature and behaviour or remarks of a sexual nature that are—and these adjectives have been added to narrow the definition—"demeaning, seductive or exploitative."

Over the past year, some concerns were raised about



this single level as the College of Physicians and Surgeons task force recommended three separate levels of offence. Our consultations indicate that a single level meets the needs of most professionals as well as survivors. Health professionals and lawyers believed that three different levels of offence would make it more difficult to prove charges of sexual abuse, and survivors felt that three levels trivialized the incidents of remarks and behaviour of a sexual nature.

I should point out that survivors were particularly concerned about distinctions in the level of offence. Their experience indicated that inappropriate remarks and behaviour often function as a prelude to more serious offences. They suggested that a potential abuser might employ these as techniques for testing a patient's vulnerability, to "groom" the patient for future possibilities more physical in nature. We've taken these concerns seriously in proposing amendments to Bill 100.

I should also draw your attention to the matter of penalties. The penalty for certain acts of sexual abuse, such as physical sexual relations, is revocation of a professional's certificate of registration for a minimum period of five years and a fine of up to \$35,000. For other acts of sexual abuse, the penalties range from a reprimand to revocation of certificate of registration.

Mandatory reporting is another area that has been discussed at length. The proposed legislation requires that any regulated health professional who has reasonable grounds for believing that a colleague has committed an act of sexual abuse must report it to the appropriate college. Failure to report is a provincial offence.

Currently, Bill 100 has a provision that allows for exceptions to mandatory reporting. We are proposing an amendment to delete this provision so that there can be no exceptions to the mandatory reporting requirement.

To provide additional sensitivity to complainants' needs, as well as flexibility to make mandatory reporting work, the government is considering amending the bill to allow assessment and remediation of members reported under category 1(3)(c), pertaining to words or behaviour of a sexual nature. This in fact would provide a more responsive solution to correcting inappropriate behaviour and ensuring that the course of remediation, whether it be therapy or education, has been effective.

During the consultations, concerns were raised about the potential effect of mandatory reporting on the climate of the workplace. We feel that this concern should be examined in the context of the hostile environment or chilly climate, as well as jeopardy of care, resulting from sexually demeaning remarks or behaviours. The negative effects of such environments have been well documented. That's why we're confident that the text in this section strikes an appropriate balance between the interests of potential victims and those in positions of power.

I should also point out that the mere fact that an incident has been reported does not make the alleged perpetrator guilty. The college of which a professional is a member thoroughly investigates all reports to determine if there is enough evidence to proceed to a hearing. If the basis for a hearing is insufficient, the complaint will not be pursued.

With regard to mandatory reporting, I should alert you to one significant change: The government has suggested an amendment to exclude provisions for reporting incompetence and incapacity. Many survivors argued for retention of these provisions. We look forward to hearing about possible alternative ways of protecting consumers against incompetence which might go unreported.

Another issue that has been discussed extensively throughout the consultation process is funding to cover the costs of counselling or therapy for survivors of sexual abuse. When a college finds a member guilty of sexual abuse, there is a provision in the legislation that the college must provide financial help for therapy and counselling to the survivor.

Each of the 21 colleges will be required to establish and fund programs for this purpose. Each college may decide how it wants to raise the money, but standards of survivors' access must be uniform across all colleges. The maximum amount provided to the survivor will be in the \$10,000 range.

This funding recognizes that the consequences of sexual abuse are devastating and that survivors may require specialized care. Survivors generally feel \$10,000 is modest, but are pleased that no assessment, psychological or other, will be required to receive the funding.

During consultation, it became clear that survivors should be free to choose the type of therapy that best meets their needs, even when the therapist is not covered by OHIP. If the survivor chooses to seek help from a psychiatrist, OHIP will pay.

The last two government amendments I wish to bring to your attention are intended to strengthen the rights of complainants at disciplinary hearings.

As I'm sure you're aware, in the past many survivors of sexual abuse have failed to come forward because they have found the disciplinary process demeaning and harmful. In crimes of a sexual nature, impugning the character of complainants is a familiar tactic of the defence, and the adversarial nature of such proceedings may contribute to the further victimization of complainants.

In the course of our consultations, complainants repeatedly highlighted their lack of input into how the evidence was presented by the prosecutor and their lack of a voice at a hearing. They also noted that they were excluded from the hearing, while the professional was allowed to be present throughout.

#### 1550

After listening to many different stories on similar themes, we recognized that these conditions intensified complainants' feelings of powerlessness. In fact, I think it's appropriate to say that for many survivors the disciplinary process became a second silencing, resonant of the initial abuse they endured.

Bill 100 has been amended to strengthen survivors' rights in this regard. This section requires the defence to provide at least 10 days' notice prior to the hearing of any expert evidence they intend to introduce. This will allow complainants to prepare a defence if accusations are to be made about their behaviour or character.

With Bill 100, college disciplinary committees have

also been given power to grant non-party status to complainants whose good character, proper conduct or competence is in question or whose psychiatric history is introduced into evidence.

Another concern that was raised by survivors of sexual abuse during consultation is that they are likely to suffer post-traumatic stress disorders. So for the first time, Bill 100 provides non-party status to be granted to groups that can help the discipline committee in its deliberations. The bill gives panels the authority to allow groups to participate in a hearing with a view towards putting the survivor's experience in context. The scope of participation of both complainants and groups granted non-party status may range from making written submissions to cross-examining witnesses.

In closing, let me say that we are confident that with these proposed amendments Bill 100 is workable. The bill balances the interests of the survivors of sexual abuse and health care professionals while responding to consumer demands for greater accountability of regulated health care professionals.

I should point out, however, that Bill 100 also contains a mechanism for its continuing evolution. The legislation will be monitored by the Health Professions Regulatory Advisory Council, which will report to the minister on its overall effectiveness no more than five years after the law comes into force.

Once again, let me stress the need for moving quickly on these amendments. Recent decisions at the Divisional Court level have dramatically reduced the stiff penalties imposed by the College of Physicians and Surgeons of Ontario on doctors found guilty of sexual abuse. We can only imagine the effect this has had on survivors who may be thinking about coming forward with their stories. Judges who do not acknowledge the seriousness of sexual abuse involving a breach of trust obviously need further education about its devastating effect on survivors. Although no government can ever write legislation that will preclude a court from opening up tribunal decisions, it can clearly set out definitions of sexual abuse with equally clear penalties.

There's an urgent need for one set of rules that everybody can follow. I'm confident that Bill 100 meets that need. The time is right, as passage of this bill will dovetail with the proclamation of the Regulated Health Professions Act by the end of the year. It is absolutely critical that consumers receive the full protection of the new legislation as soon as possible, protection which can only be fulfilled with the amendments provided by Bill 100. Its value to survivors of sexual abuse and its vital importance to the public interest cannot be overestimated.

**The Chair:** Thank you very much, Minister. I know you have to go, but if there are any questions, do you have a few minutes?

**Hon Mrs Grier:** Yes, indeed I do. If not, I don't know whether Christine Henderson, who's legal counsel on this bill, has been introduced, but she will certainly be here and I think is going to take the next stage of going through some of the legislation.

**The Chair:** I thought I would just ask the members,

given that you will have to go, if perhaps they would like to ask some questions. I also seek direction from the committee if they would prefer to go through the briefing on the bill and then make comments, but we may want to begin with questions.

**Mr Jim Wilson (Simcoe West):** Without infringing upon my right to point out perhaps some improvements to the bill as we proceed through the hearings, I just want to compliment the minister on her statement today. I thought it was extremely thorough and thoughtful, and certainly my intention and that of my caucus colleagues is to be as cooperative in this process as possible, and I give you that stated on the public record today.

**The Chair:** Thank you.

**Hon Mrs Grier:** Let me respond very gratefully and acknowledge that. Also, as I said in my opening comments, the member, as well as the member for Halton Centre, has been very much part of it. It has been an extremely constructive and productive dialogue among all three parties as we've tried to produce, with a very important piece of legislation, the best possible and most workable legislation we could, and I thank you for that.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Thank you, Madam Minister. I'd like to go to page 3, if I may, because I wasn't part of those discussions and certainly there weren't many who were. I know this is a part that is worrying several of the professionals, so you may want a minute or two to expand further on the section regarding additional sensitivity to complainants' needs and the process now of assessment and remediation of members reported under this category. Would you like to say a little more about why you've done that, why you think that's going to be helpful; just expand on your statement?

**Hon Mrs Grier:** I think it essentially responds to the need that was expressed for some range of options under the legislation and to have some flexibility. While there were those who said that the nature of the offence should be divided into the three parts that had originally been identified, the conclusion of most people was that no, it was preferable to have a single offence but acknowledge that within that there needed to be a range of measures taken, whether that be penalties or remediation. It was as a result of those discussions that we came forward with that amendment.

**The Chair:** Is it the wish of the committee to proceed to the technical briefing? Seeing no objection, Minister, thank you for coming before the committee.

**Hon Mrs Grier:** I appreciate it and, as I say, will be following with interest the deliberations and wish you well. I gather there are a lot of people who wish to appear. We had hoped that as a result of the discussions over the summer we might diminish your load, but it doesn't appear we've done that, so I apologize for that.

**The Chair:** Thank you. I believe the parliamentary assistant is going to join us at the front.

**Hon Mrs Grier:** I think the member for Simcoe Centre is going to be carrying it.

**The Chair:** It somehow doesn't seem appropriate that he's not there. I'll ask the two opposition parties if we can proceed with the technical briefing and if there are



any comments you wish to make, that you do so at the end, okay? With that, parliamentary assistant, perhaps you could have those who are going to participate identify themselves and then go ahead with the briefing.

**Mr Paul Wessinger (Simcoe Centre):** Yes, we'll ask Christine Henderson, first of all, to introduce herself.

**Mrs O'Neill:** Excuse me, Mr Chair. Before we begin, are we going to be referring to these amendments that were passed out? We've only got one between the two of us. Are there more copies?

**The Chair:** I don't know whether they'll be referred to, but the clerk has some other copies and will pass those out. Please go ahead, Ms Henderson.

**Ms Christine Henderson:** Good afternoon. My name is Christine Henderson and I am a counsel with the Ministry of Health's legal services branch. I am going to provide you with an overview of the provisions of Bill 100 and the motions to amend the bill this afternoon. I'm going to approach the task by discussing general areas in the bill and the motions in a way that will not be chronological according to the sections in the bill, but in a way that I hope is logical.

**The Chair:** The committee is all in favour of logic.

**Ms Christine Henderson:** Good. I would ask you to make a note of your questions, and perhaps we can get to the bulk of them after the overview. At this time, I'd also like to introduce Ella Schwartz, who is a policy analyst from professional relations branch; and also the minister's special adviser, Patricia Bishop, who may or may not now be in the room at the moment, who will also be fielding some of the policy questions.

You may wish to have reference to the actual provisions of the bill and the motions as I address these provisions, so I would refer you to the appropriate page number in the consolidated report, which is in your briefing books at tab 8. You may wish to locate the report.

#### 1600

The consolidated report, you will note, contains provisions relating to the Regulated Health Professions Act, 1991, which I will refer to as RHPA; Bill 100, which I will refer to as the bill; and to the proposed government amendments.

We will now discuss the significant changes the bill makes to the RHPA, along with the proposed government amendments to the bill.

Pursuant to the bill's provisions, sexual abuse of patients is made an act of professional misconduct. How does the bill define sexual abuse? If you turn to page 7 of your consolidated report, you will note that "sexual abuse" of a patient by a member means sexual intercourse or other forms of physical sexual relations between the member and the patient; touching, of a sexual nature, of the patient by the member; or behaviour or remarks of a sexual nature by the member towards the patient that are demeaning, seductive or exploitative."

You will note that the government amendment to Bill 100, as the minister noted, changes the current provisions in the bill under clause 1(3)(c).

Bill 100 places new mandatory duties upon individual regulated health care professionals and upon institutions that employ them.

At page 19 of your consolidated report you'll find the mandatory reporting provisions relating to regulated health professionals set out. Members of colleges must file a mandatory report if they have reasonable grounds to believe in the course of practising the profession that another member of the same or a different college has sexually abused a patient. This means, of course, that the statutory obligation to report sexual abuse of a patient will apply to members of one's own college as well as to members of other colleges.

You will note that the proposed government amendment to Bill 100 has deleted the mandatory reporting requirements relating to incompetence, incapacity or acts of professional misconduct designated in college council regulations.

A member of a college will not be required to file a report if he or she does not know the name of the member who would be the subject of the report, the alleged abuser.

If a member is required to file a report because of reasonable grounds obtained from his or her patients, the member must use his or her best efforts to advise the patient about the requirement to file before actually filing the report. That's at subsection (5) at page 19.

Finally, the bill provides for exceptions to the mandatory reporting scheme, and such exceptions must be prescribed by regulation. As the minister noted in her address, the ministry in fact proposes that these provisions be struck out. That's subsection (4) within section 85.1 at page 19. Those provisions will also be struck out under the government's proposed amendments.

At page 20 of the consolidated report you will note that a similar mandatory reporting obligation will be placed upon operators of facilities where one or more members of colleges practise, if the person who operates the facility has reasonable grounds to believe that a member who practises there has sexually abused a patient. Thus, new statutory duties will be placed upon operators of hospitals, nursing homes and other institutions, wherever regulated health professionals are employed. You will note again that the government amendment to Bill 100 strikes out the requirements of reporting by facility operators in relation to incompetence, incapacity or designated acts of professional misconduct.

If the name of the member who is alleged to have committed the sexual abuse is known, the report must be filed in writing with the registrar of the college where the alleged abuser is a member. The written report must contain the following information, and this is set out at page 21 of your report: the name of the person filing; the name of the alleged abuser; an explanation of the alleged sexual abuse; and finally, the name of the patient who may have been sexually abused, but only where the patient or his or her representative consents in writing to the use of the patient's name.

What about timing? When must a report be filed with the appropriate registrar in the case of alleged sexual



abuse of a patient? The report must be filed within 30 days after the alleged event occurred, unless the reporter has reasonable grounds to believe that the alleged abuser will continue to sexually abuse that patient or other patients, in which case the report must be filed immediately.

If you look at your consolidated report at page 21, you will see some minor changes made to the provisions of the bill by the proposed government amendment. These are as follows, if you wish to follow along:

—Subsection (2) of 85.3, strike out “in a case of alleged sexual abuse.”

—Subsection (3), strike out the entire subsection.

—Clause (4)(c), strike out the words “misconduct, incompetence or incapacity and an explanation of the grounds of the member filing the report.”

—Finally, subsection (6), again strike out “in a case of alleged sexual abuse.”

Still at page 21, if a member is required to file a report but is providing psychotherapy to a college member who would be the subject of that report, the report must also contain the opinion of the counsellor, if he or she can form one, about whether or not the alleged abuser is likely to sexually abuse patients in the future.

At page 22, the bill goes on to provide that if such a report is filed, an additional report must be filed immediately if the psychotherapy ends.

At page 23 of the consolidated report, the bill's provisions state that a person who terminates the employment of a member of a college or who imposes restrictions on their privileges or does anything to restrict their practice for reasons of professional misconduct, incapacity or incompetence, must file a written report setting out the reasons for doing so within 30 days.

Similarly, if a person intended to terminate or restrict a regulated health care professional's privileges or employment for those reasons but did not do so because the member voluntarily resigned or voluntarily relinquished privileges, then a report must again be filed within 30 days, setting out the reasons why there was an intention to act.

These provisions apply to every person who employs or offers privileges or associates in partnership or otherwise with a member to offer health services.

Finally, no action or other proceeding can be instituted against a person for filing a report in good faith.

**1610**

It's also important to note at this juncture, as the minister noted, that the government is intending to table a motion that would permit colleges, in appropriate cases, to refer members who have been accused of sexual abuse under clause 1(3)(c)—that is, sexual abuse constituting words or gestures that are demeaning, seductive or exploitative—to assessment and to possible remediation, rather than discipline.

The bill also provides for stiff penalties for failure to report cases of sexual abuse. Anyone who contravenes their obligation to file a report is guilty of an offence and upon conviction is liable to a fine of not more than

\$25,000. That's at page 27 of the report.

Finally, at page 26 of the consolidated report, the bill states that no person shall do anything to the employment or to a contract for services of a reporter in retaliation for filing a report or for making a complaint, as long as the complaint was made or the report was made in good faith.

We now turn to the general area of funding for therapy and counselling. As you know, all colleges will be responsible, pursuant to the bill's provisions, for establishing a program to provide funding for therapy and counselling for persons who were sexually abused by members while they were patients. The patient relations committee of each college shall administer the program.

A person will be eligible for funding if a panel of the college's discipline committee makes a finding that the person, while a patient, was sexually abused by a member, or if the patient meets such other prescribed alternative requirements as are set by college councils. These provisions, by the way, are set out at page 24 also.

A person's eligibility for funding will not be affected by an appeal from the panel's finding. The motions tabled by the government to amend the bill also include provisions respecting that there be no assessment of a person who receives funding. In other words, a person will not be required under these provisions to undergo a psychological or other assessment before receiving funding. The no-assessment provisions are not included in your consolidated report, but you may wish to add them at page 24 if you wish. They do form part of the government's motions to amend.

Over at page 25 of the report, you'll note that proposed amendments to the bill state that a person who is eligible for funding is entitled to choose any therapist, subject to these restrictions: The therapist must not be a person who has any family relationship to the person receiving the counselling; the therapist must not be a person who has at any time been found guilty of professional misconduct of a sexual nature or who is guilty of a criminal offence in this regard; if the therapist is not a regulated health professional, the college may require that the eligible person sign a document stating that he or she understands that the therapist will not be subject to professional discipline.

Funding for therapy will be paid to the therapist directly and may only be used for the purposes of counselling or therapy.

Finally, funding provided to an eligible person will be reduced by any amount that the Ontario health insurance plan or a private insurer is required to pay.

You should note also, at the bottom of page 25 of your consolidated report, that the subrogation provisions which are there have been deleted from the bill by the government's motions to amend. You may wish to strike out subsection 11 now from your consolidated report.

The government intends to table an amendment that would instead provide colleges with a statutory cause of action to recover funds that they have expended for the purposes of counselling. Such provisions, of course, would never interfere with a patient's right to sue civilly,

to pursue the perpetrator and sue civilly.

At page 28 of the consolidated report, proposed government amendments to the bill provide regulation-making powers to the colleges that will permit them wide latitude to develop schemes including insurance schemes to support the program for funding. Colleges will be enabled to make regulations that require members to pay amounts to fund the program and to participate in arrangements set up by that college or groups of colleges, should they chose to work within a group scheme, in which members or classes of members will have to pay prescribed amounts to support the program for funding.

Further, college councils will be able to make regulations authorizing the patient relations committee to require therapists who are providing counselling under the program and persons receiving such counselling to provide written statements signed by these parties containing details of the therapist's training and confirming that the therapy and funds provided for it are being devoted only for the purposes of counselling.

At page 13 of your report, the government's amendments will also permit colleges to require the perpetrator to reimburse the college for funding expended for therapy and will also permit the college to require of the perpetrator suitable security to guarantee the payment of those amounts.

For the purposes of the programs established for funding for therapy and counselling, you will recall that the funding must be in accordance with ministry regulations.

What the government is proposing is that these regulations set a maximum amount of funding that may be provided to an eligible person—the minister alluded to this—and the maximum amount will be approximately \$10,000 worth of therapy or counselling, about the amount the Ontario health insurance plan would pay for 200 half-hour sessions of outpatient psychiatric care.

The regulations will also provide that the period of time within which a person can have access to funding is five years from when the eligibility was established or from the day the panel commenced hearing the matter at issue.

There are procedural changes as well incorporated into the bill's and the amendment's provisions.

At page 10 of your consolidated report, non-party participation in disciplinary or incapacity proceedings is addressed.

Under these provisions, a panel may now allow a person to participate in such a hearing if the good character, propriety of conduct or competence of person is at issue in the hearing or if the participation of the person would be of assistance to the panel. The panel will determine the extent to which the person is allowed to participate and may allow the person to make oral or written submissions, to lead evidence and to cross-examine witnesses.

The government's amendment respecting disclosure of expert evidence is set out at page 11 of your report and essentially provides that where expert evidence is led by someone other than the college, the college must receive a copy of the expert's written report or a written sum-

mary of that evidence and the college must be made aware of the identity of the expert at least 10 days before the hearing.

#### 1620

At page 15 of the report, the government amendment to the bill provides that, in the appropriate case, a panel may order a member who it has found has committed an act of professional misconduct or who is incompetent to pay all or part of the college's legal costs, the college's costs incurred in investigation of the matter and the college's costs incurred in conducting the actual hearing.

Again at page 13, the maximum fine in all disciplinary proceedings is increased by the bill's provisions to \$35,000.

The bill also sets out mandatory penalties for sexual abuse. Yes?

**Mrs Karen Haslam (Perth):** I have a question about something you covered a long time ago, so I wanted to be put on the list when it comes time. You did it a long time ago; I just haven't had a chance to catch Mr Beer's eye.

**The Chair:** My eye is now caught.

**Ms Christine Henderson:** Reprimands are required, and for certain kinds of sexual abuse which are set out at page 14 of your report, under the bill's provisions, the health professional's certificate of registration must be revoked.

If you'll note at page 14, the government's motions to amend have deleted subparagraphs vi, vii and viii. You can strike those out, subparagraphs vi, vii and viii, the bottom of page 14, under Bill 100 provisions.

Also at page 14, the government amendments will require a panel of the discipline committee to consider any written statement that has been filed describing the impact of the sexual abuse that was committed towards the patient. All such statements must be provided to the member, the member's counsel and to the college.

At page 16, you will note that a person whose certificate of registration has been revoked due to sexual abuse may only apply for reinstatement five years after such revocation. You will also note at page 16 that panels will not be able to issue new certificates of registration to applicants whose certificates have been revoked for sexual abuse unless certain prescribed conditions have been met. Those proposed conditions are set out at page 16, at the bottom. These conditions reflect the task force report's recommendations.

Finally, information kept in the register and made available to the public has changed. Now the results of every disciplinary and incapacity proceeding completed within six years before the register was last updated must be made available to the public. Where the member was found to have committed sexual abuse constituting physical sexual relations or touching of a sexual nature, the information will be on the register and available to the public for 10 years.

In addition, where a matter that has been decided by a panel of the discipline committee is under appeal, the register shall note that information, and the results of every proceeding contained in the register will include the



following information: the panel's finding, the particulars of the grounds for the finding, the penalty that was imposed upon the member and any reprimand that was given.

Thank you for your attention. I hope this has been helpful and we now look forward to your questions.

**The Chair:** Thank you very much for that presentation. We will then move to questions.

**Mr Jim Wilson:** That was extremely comprehensive, counsel, and very quick. I had great difficulty writing down my questions at the speed at which you were going, but I appreciate it, because I know there's a lot of stuff here and we had seen it; we've had this before us for a little over a week.

I had a quick question, if I can think of what it was, on page 19, 85.1(5), a minor question. The section reads, "If a member is required to file a report because of reasonable grounds obtained from one of the member's patients, the member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so."

Can you perhaps give an example of where a member would obtain the reasonable grounds from the patient? Can you think of any scenario to put that into layman's language for me?

**Ms Christine Henderson:** I'm going to ask Ella to jump in here as well, if I get the scenario not quite right.

I believe this contemplates, as well as other situations, the kind of situation where in the course of an appointment, say, with Dr Jones, the patient reveals some incident of sexual abuse that occurred at a hospital involving Nurse Smith and because of the circumstances described by the patient, the physician at issue has reasonable grounds to believe that sexual abuse of this particular patient occurred—

**Mr Jim Wilson:** Would that not be hearsay in that case, though? What's the reasonable grounds test in layman's terms there? When you read the provision or when you scanned over it, it seemed to me that was a case where perhaps you're getting secondhand knowledge of potential abuse.

**Ms Christine Henderson:** It's hearsay, clearly; there's no direct observation in this case. If perhaps the patient also displays particular physical symptoms that could conceivably be caused by a fall down the stairs or some other kind of—you know, along with a story documenting touching of a sexual nature, it's quite possible that particular physician might say, "These are reasonable grounds to believe the event occurred, even though I didn't directly observe this conduct."

**Mr Jim Wilson:** Okay, and the rest of that provision is—there's a "shall." "The member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so." Obviously, it's to ensure that the patient is aware of the process that's about to begin because the member at that time has reasonable grounds to believe that sexual abuse may have occurred. My reading of this is that the member's required to explain this process to the patient at that time, to say to the patient, "If we go further, here's what may happen to that

physician who allegedly abused you." Is that what's to happen here?

**Ms Christine Henderson:** I believe that "shall use his or her best efforts to advise the patient of the requirement to file the report" means simply that. I don't believe it would entail discussion of a disciplinary process involving that particular member of a college who was the alleged abuser. What that speaks to, if you recall, is that the information that must be reported in the report includes the patient's name but only if the patient consents in writing to the use of her name. So in our scenario, I would imagine that—

**Mr Jim Wilson:** That's what would be going on at this point.

**Ms Christine Henderson:** This would be going on at this point. Of course, if there's no immediacy in terms of a threat to that patient or other patients perceived by the potential reporter, they have 30 days within which to use their best efforts to advise the patient about the requirement to file. But unless that patient gives consent, the name of that patient will not be included in that report.

1630

**Mr Jim Wilson:** May I, Mr Chairman, ask another quick question? Well, I guess none of the responses or questions are that quick. It is complicated legislation, no doubt about it. It's a serious matter, though.

Page 21, subsection 85.3(6): The confidentiality measures are contained earlier, so I'll ask you to refer to those in responding to this question. With subsection (6) at the bottom of page 21, a member is in psychotherapy. I'm just wondering about the therapist-patient confidentiality relationship. There's mandatory reporting here. What confidentiality provision is there? I know this is a sensitive issue with, as it were, perhaps one physician reporting another physician, and physician 2 is actually a patient. Can you explain the thoughts of the ministry there and the discussions with the CPSO with respect to that? I imagine that will come up again in the public hearings.

**Ms Christine Henderson:** You're right; that's a very critical policy matter. Because there was discussion about this and there have been submissions about this, I wonder if I could refer that question to Ella to help.

**The Chair:** Could you go to the table, please? We're being televised.

**Mr Jim Wilson:** You need a better camera angle.

**The Chair:** It just helps. That way, everybody's looking forward and not craning their necks. If you would be good enough to identify yourself, then please go ahead.

**Ms Ella Schwartz:** I'm Ella Schwartz. I'm a policy analyst at the professional relations branch.

We heard a lot of different considerations about whether a professional who was in therapy and trying to have his or her problem resolved ought to be the subject of a mandatory report. It's actually been very complicated. We've heard from some professional bodies that absolutely there should be confidentiality; other professional bodies have said no, it should be the subject of a report. Even within the professional bodies there has



been debate. Interestingly, the task force report originally said to maybe not report and then came down in its final version and said that absolutely you have to report.

It's been a very difficult issue to resolve. How the ministry is trying to resolve it is, as you know, as both Christine and the minister said, we're going to take out any possibility of there being exceptions to mandatory reporting. You will have to report.

But what will happen with those reports is that eventually they end up at the executive committee, and the executive committee—right at the top of page 10 of the consolidated report, subsection 36(2)—is required to “take into account any opinion...as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future.”

So you have the report, but what happens to the report is discretionary. You can take into account the fact that this member has been going to psychotherapy and the situation may be able to be resolved that way.

**Mr Jim Wilson:** Are there any guidelines for the executive committee at this stage?

**Ms Schwartz:** You mean about how the executive committee would determine that?

**Mr Jim Wilson:** Yes. The way I read this is that this is sort of the screening process prior to going to the disciplinary committee. I'm wondering what the criteria are, or are we going to wait for cases to develop their own criteria?

**Ms Schwartz:** What you've got on page 21 is what the executive committee has, an opinion of the member filing the report, if he or she is able to form one. That's at the bottom of page 21, subsection 85.3(6).

**Mr Jim Wilson:** So they will rely on the professional opinion at that point.

**Ms Schwartz:** They may rely on the professional opinion. That would be one possibility.

**The Acting Chair (Mrs Yvonne O'Neill):** Anything further, Mr Wilson?

**Mr Jim Wilson:** I do have others, but I'll yield the floor at this point, Madam Chair.

**Ms Haslam:** On page 23, I'd like to know what constitutes in good faith. In the RHPA provisions, you are indicating that no action or other proceeding shall be instituted against a person for making a report in good faith under this section. I'd like clarification of your definition of “in good faith.” And who makes the decision about whether this person has put that report out in good faith?

**Ms Christine Henderson:** Ultimately, the court would decide, in the event that there was a suit, but “in good faith” is generally considered to be a very broad legal test that embraces a very full protection for reporters. I would suggest that, unless a report were made with a malicious intent, the good-faith test would protect the reporter.

**Mrs Haslam:** You'd have to prove malicious intent in the court, though.

**Ms Christine Henderson:** Yes.

**Mrs Haslam:** So as your definition, it would have to

be done in the courts?

**Ms Christine Henderson:** Right. In this context these provisions have not been judicially interpreted, but I think you can be assured that this is a very broad test, “in good faith,” and the intention is to provide reporters with a very broad immunity from civil suits, as there must be in order that there be compliance with the mandatory reporting obligation. This is in fact a very broad immunity.

**Mrs Haslam:** That's all I had at this time.

**Mr Bernard Grandmaître (Ottawa East):** As a follow-up to Ms Haslam's question, I accept what you're telling me about a report in good faith, but is there a mechanism in place that would ensure that this report is more than good faith, that it is factual?

**Ms Christine Henderson:** I guess the mechanism is that before a report is made, there must be reasonable grounds for the reporter to believe that sexual abuse, as defined, actually occurred.

**Mr Grandmaître:** So I suppose every report would be made in good faith, right?

**Ms Christine Henderson:** It's hard to speculate on your question. I guess you're suggesting that there may be individuals who, for purposes of retribution, would make a malicious report?

**Mr Grandmaître:** Yes. Is there a mechanism in place to ensure that these reports don't become public, for instance?

**Ms Christine Henderson:** Yes, there are confidentiality provisions around information that is submitted to colleges; absolutely. I would think someone would take their reporting obligations very seriously. Maybe I'm being naïve, but I would find it incredible that someone would maliciously report another individual. The reporter's name forms a part of that report as well.

1640

**The Acting Chair:** I understand, Ms Bishop, you'd like to comment on this as well.

**Ms Patricia Bishop:** Yes, I'd like to pick up on this issue. The question really leads one to an examination of the complaints investigation. At that point of course there are a number of strong procedural safeguards in place at the College of Physicians and Surgeons, to take an example, but at any professional college, such that the report would be received either in writing or over the telephone, it would be documented, there would be an investigation of the person who reported, of the circumstances, of all of the facts surrounding the case. Only at that point, when all the facts were marshalled, would the college then decide to proceed or not to proceed to discipline. It would be a very full airing of the facts.

And one might note that historically, with regard to the College of Physicians and Surgeons of Ontario, a very small number of complaints proceed to discipline. I think most survivors would say a shockingly low number of complaints proceed. In general, I think the public would wonder why more complaints don't proceed rather than why so many do proceed.

**The Acting Chair:** Ms Schwartz, you have something

also to add on this one?

**Ms Schwartz:** Yes. This is probably clear but I just wanted to repeat it. The section we're talking about, 85.6, deals with the reporter and whether the reporter made the report in good faith and whether the reporter can be prosecuted for making the report in good faith. It doesn't deal with whether the person actually did what they're alleged to have done. That goes through the whole complaints and investigations process, and as Patricia was saying, there is a very careful procedural description of that.

What this is saying is that if you have reasonable grounds and make the report in good faith, you're just the reporter who believes it happened. No one can take you to court for making the report. It's not a question about taking the member to court for having done that thing they're accused of.

**Mr Grandmaitre:** So really the mechanism is the college?

**Ms Schwartz:** The mechanism for determining whether the incident happened?

**Mr Grandmaitre:** Yes.

**Ms Schwartz:** Exactly. That's the college's complaint and discipline proceeding, and that's not what this is addressed to.

**Mr Grandmaitre:** If the college, for instance, disagrees with the reporter, what other mechanisms are there in place for the reporter to pursue?

**Ms Schwartz:** The college could disagree with the reporter and say it didn't take place but recognize that the reporter validly thought so. If the reporter finds that, say, the complainant doesn't get satisfaction through the college, they can go to civil court, and, depending on the nature of what they're alleging, they could try criminal court.

**Mr Grandmaitre:** What if the college reports back that the report was not in good faith and that's it; that it's out of the question and the incident will not be considered? Can this reporter be sued?

**Ms Schwartz:** That the reporter just made it up because he has this thing against the member? Yes, and the reporter could probably also be prosecuted under their own college for not acting according to the standards of the profession.

**The Acting Chair:** Mr Wilson, you have further questions?

**Mr Jim Wilson:** Yes. On the same page, page 23, it says, "MOH is considering allowing the college in appropriate cases to refer members accused of sexual abuse under clause 1(3)(c) to assessment and possible remediation rather than to discipline." In the minister's remarks it's made it very clear that there's one definition of sexual abuse that has three parts, so to me this sounds like you can be found guilty of sexual abuse and there are different sanctions that can be applied. It seems to me that what that says is that if you're found guilty—and I'm not saying I disagree with this; I'm just asking a question—of sexual abuse under part 1(3)(c) of the definition, there is this option: to not necessarily proceed to disci-

pline but assessment and remediation.

It's been said that there's only one level. Groups, particularly survivors, that have told me there's only one level are going to be concerned. They haven't read the act, because the act is, on the surface, one level, but it's divided up into nice little things. I think we should be honest about that and get that out now and find out that there are different levels here and that different sanctions apply.

**Ms Christine Henderson:** You're absolutely right. The reporting of sexual abuse under 1(3)(c) has been a contentious issue with some of the professions and associations, not all.

This was a subject of a conference with Dr Gary Schoener, who was a specialist in the area of sexual abuse. In answering a question from a member of a college, he said that in his view it was absolutely necessary to require reporting of incidents of 1(3)(c). His view, however, was that the disciplinary route may not always be the way to deal with such cases of sexual abuse. Yes, they're serious; yes, they sometimes indicate that a member of a college has serious problems and may proceed to commit other kinds of acts of sexual abuse. Or it may be someone who is not really living in the 1990s and needs some sensitivity training, needs some communications skills updating; the disciplinary route may simply be unhelpful in such cases.

So we were left to deal with the problem of serious incidents of behaviour or remarks that are demeaning, exploitative or seductive, of a sexual nature, and a mandatory obligation to report them, but with perhaps a lack of options to effectively deal with these kinds of cases. What the government proposes to introduce in the motion would provide colleges with the discretion to deal, in appropriate cases, with these matters by means of an assessment and by means of a tailored program to suit that particular individual's needs.

**Mr Jim Wilson:** Then with respect to the wording that's been provided on page 23—I guess we have only three days of public hearings or something. I'm not comfortable with just leaving that as it's worded here. When can we see the ministry proposals for that? I appreciate the ministry's problem here and at this time probably agree with the direction you're going. But upon reading, I think some people who clue into this are going to be worried about it.

**Ms Christine Henderson:** I don't have any specific instructions, but I think we'd be ready next week to share them with you. We certainly want to give you enough time to consider them fully and to examine them.

**Mr Jim Wilson:** I have another question, a quick one. This is page 13, dealing with fines. I may be right out to lunch on this one, but we had a lot of discussion with groups and individuals about the fines perhaps going back to the colleges or something to help pay for survivors' therapy or whatever might be required. I know that's not the case here and the colleges are left with coming up with their own schemes with respect to funding the survivors'—what are we calling that, the \$10,000 worth of treatment that can be used? What is that called?



1650

**Ms Christine Henderson:** The funds for therapy or counselling.

**Mr Jim Wilson:** Yes. There was another name Marilou used to use, and I think I actually introduced something in the House with respect to this. I can't keep up with my own work.

This \$35,000 fine mentioned on page 13 isn't any different from the RHPA, except it's higher. The money still goes to the Minister of Finance. Do you want to explain that to me? There are a lot of groups who are going to wonder why the Minister of Finance makes \$35,000 when someone's convicted of wrongdoing.

Some of the groups we're dealing with, I think it's fair to say, don't realize that most fines do go to the province of Ontario. Particularly with respect to this, though, they thought it was going to go back to help survivors.

**Ms Schwartz:** Because of the way the consolidated revenue fund is organized, money that comes in doesn't get targeted towards something specific; it gets put into the general fund and then gets put out. It would be quite precedent-breaking, as I understand it, for the Ministry of Finance. It would also be quite precedent-breaking for the Attorney General to take a fine from an administrative agency, which is what this is, and have a fine go back towards the purposes of that agency rather than into the consolidated revenue fund.

It would also not necessarily meet the needs of the program, because some people, we've discovered—an unhappy story—actually abuse more than one person. They can abuse many people, and \$35,000 is three and a half people. If you get someone who has abused 20 people, and we've encountered them recently, this wouldn't cover it.

What we tried to do was address the issue which we felt was underlying this, that the money should come first of all from the abuser, not necessarily through the fines. We addressed that in various ways, and one way was exactly that, on page 13, that the discipline committee could require the member to reimburse the college and could also even require the member to post a bond for all the money the member might be liable for. Also, there are regulation-making powers at the back to require the member to maybe carry insurance for this kind of thing.

**Mr Jim Wilson:** Let me see if I'm clear. It's the colleges that will pay for the victims compensation fund and the \$10,000 maximum for the therapy.

**Ms Schwartz:** First of all, the college will go after the person who's been found guilty of abuse, and only if the person who's found guilty of abuse doesn't have the money will the college have to pay. The first person you turn to is the abuser.

**Mr Jim Wilson:** But the college pays the \$10,000. Why does the province get \$35,000? You're not putting any money into the victims compensation fund. It seems a little unfair to me.

**Ms Schwartz:** The college pays the money and gets reimbursed.

**Mr Jim Wilson:** Is that true?

**Ms Schwartz:** That's what we said on page—

**Mr Jim Wilson:** But gets reimbursed by the abuser, not by the government. The government makes money on this through the normal fine system.

**Ms Schwartz:** Right, the normal fine system is in place here.

**Mr Jim Wilson:** I bring this out because I just met with a group that thinks this \$35,000 is going into the victims compensation fund, and it's not. The government doesn't pay for anything. The colleges, the individual members, through whatever method they come up with, pay the \$10,000 worth of therapy that may be required. Is that true?

**The Acting Chair:** Ms Bishop, you seem to want to say something about this. Would you like to do that formally?

**Ms Bishop:** Yes. Mr Wilson is correct in that the \$35,000 fine would go to the Minister of Finance. In fact, Ella did extensive investigations over the course of the last nine months, I would say. Because consumer-survivor advocate groups had approached us and said, "No, there is a matter of justice being done and seeing that justice is done, and we'd really like this money to go to the survivors" etc, Ella did an incredible amount of investigation and found that, bureaucratically speaking, and unfortunately we do operate within this bureaucracy called government, it really is not feasible to do that. We really tried hard but we could not find a mechanism to allow that to occur.

**The Acting Chair:** Have you got a comment, Mr Wilson, or do you have another question?

**Mr Jim Wilson:** No. I think that comment stands on its own.

**The Acting Chair:** You've completed your questioning then?

**Mr Jim Wilson:** Yes. Thank you.

**The Acting Chair:** Do you have another comment, Ms Bishop?

**Ms Bishop:** Yes. I wanted to respond to the second-last issue that Mr Wilson raised regarding referring certain cases to assessment and possible remediation.

You're quite right, the wording is vague at this point. For your information, the ministry conducted a meeting with both professionals and survivors in late October to see what the feeling was about this issue. In fact, survivors and professionals seemed to be equally supportive of this mechanism, and the challenge now is to get it right.

I'd also like to point out though that it does allow us to put forward a somewhat broader net in that individuals who are accused, and then there's an investigation and facts are known, but perhaps the name of the survivor, of the complainant, is not available or is not permitted to go forward—she says, "No, I don't want my name to go forward"—nothing could occur in that case, as you know. Under this regime, something could occur. So in many cases, it will allow the colleges to be more proactive than they could otherwise be.

**Mr Jim Wilson:** Can I respond to that?



**The Acting Chair:** Is it directly related to this?

**Mr Jim Wilson:** Yes, directly. I am pleased to see the government's come around to that, because I recall having a much different discussion some time ago.

Correct me if I'm wrong again, but to me also, in addition to what you've just said, which I think is quite correct—I know the wording is tricky here—to be absolutely politically correct, clause (3)(c) says "behaviour or remarks of a sexual nature by the member towards the patient." It's the least sexual abuse; none the less it is sexual abuse.

I had a very strong concern that, had you not pursued what you just described, in fact, patients may have felt inhibited from coming forward, saying: "My doctor really has to clean up his act. His jokes are inappropriate, his talk is inappropriate, but I don't want the poor guy to lose his licence, so I won't report him." What you're telling me is this will allow another mechanism, so he may not necessarily lose his licence but action will be taken.

**Ms Bishop:** That's exactly the idea.

**Mr Jim Wilson:** I appreciate that.

**Mr Stephen Owens (Scarborough Centre):** I'm sorry I missed the first part of the briefing. Under section 73, the issue with respect to reinstatement, could you talk to me about that?

**The Acting Chair:** Mr Owens, could you refer to the page? We've been doing that.

**Mr Owens:** Sorry, Page 16.

**The Acting Chair:** Thank you. Do you want to rephrase your question, just so we'll get the answer you're looking for?

**Mr Owens:** In terms of reinstatement of a professional who has been found guilty of sexual abuse, I'd like to hear a little bit more about what the thinking is in terms of the conditions on which that professional's readmission would turn, the kind of philosophy that's going into the thinking on this.

When I read the statements that are provided in the explanation, I feel some level of discomfort. There are clearly two schools of thought out in the world these days: an abuser is an abuser is an abuser, or the second school of thought is that a person can be rehabilitated. I guess I'm not clear on the direction that the ministry is looking to provide to the colleges on this issue.

1700

**Ms Christine Henderson:** The reinstatement conditions would form part of a regulation college councils would make. The ministry's position, in answer to your question, is that the best way to approach this question is to accept the recommendations of the task force report. Those recommendations, generally speaking, are set out in what you see before you at page 16 at the bottom.

**Mr Owens:** Right.

**Ms Christine Henderson:** You have to remember that when the member's certificate of registration is revoked for sexual abuse of a patient, what this bill and the amendments do is say that this is an extremely serious matter. This revocation will be in place and the member

will not be permitted to apply for reinstatement of his or her certificate until five years have elapsed.

I'm sure Ella or Patricia can give us more information, but the survivors and the advocates for the survivors' groups were very, very clear that if someone's certificate of registration has been revoked for reasons of sexual abuse, there should be very strong consideration given as to how this person has been rehabilitated, about what steps they have taken to rehabilitate themselves. Yes, I think what you're saying is that these conditions are tough, and the ministry's position is that they ought to be.

**Mr Owens:** My concern quite frankly is that they may not be tough enough. I guess that in terms of understanding the five-year period—and maybe a policy person is better—why was the term five years chosen? Is there a particular magic about that time period, or was it felt that five years is an onerous penalty and that after that period the practitioner should be able, if interested, to demonstrate that he or she has been rehabilitated?

**Ms Schwartz:** I think it was felt that, as you said, mostly an abuser is an abuser is an abuser, but there could be some cases—research is very preliminary on this in the psychological field, but they have found that in some cases an abuser may be able to be rehabilitated, although it's very rare. But we wanted to leave the door open for those few cases that an abuser could be rehabilitated.

We wanted to make sure that the conditions of reinstatement were very strict, and frankly we don't think they'll be met that often, probably hardly ever, but we did want to leave open the door that sometimes, under some circumstances, a person could come back to practise. Five years is a long time when you haven't practised your profession, and it could be very unlikely just because it's five years. If for no other reason, if there's no other conditions, even that would make it unlikely that you'd come back.

There are all these other conditions and other things you'd have to prove, but we couldn't really shut the door altogether. We wanted to keep it open a little bit so there could be a possibility of reinstatement.

**The Acting Chair:** Ms Schwartz, you've just made a very general statement and it could be considered a very serious statement. Have you got data to back up the statement you just made regarding rehabilitation possibilities? I think it's a very important issue in this matter and I think we should try to see if you have those kinds of data.

**Ms Schwartz:** That it's unlikely that a person could be rehabilitated?

**The Acting Chair:** Yes. Have you got data for that?

**Ms Schwartz:** There isn't much data available on that. We don't really know. The data that are available seem to show that, but there isn't much data available on it altogether. One of the reasons we wanted reinstatement provisions is that the research on this, as I said, is in such a preliminary stage.

**Mr Owens:** I think, if I can maybe add some supplementary information—and I'm certainly not an epidemiologist or a researcher—in terms of the issue itself, it's

only very recently that it's become an issue qua issue that's actually out there in the public minds. That's not to say that these problems haven't been going on for a long, long time, but in terms of quantifying them for the purposes of gathering data, my assumption is that it hasn't been yet put to researchers to look at this issue.

**Ms Schwartz:** I think people are just now beginning to look at the different circumstances under which a person might commit this kind of abuse, or the different categories of people who might commit this kind of abuse. As I say, it's at a very preliminary stage.

**Mr Owens:** I guess in terms of, again, the return of licence to practice, would you be looking at if in fact all the criteria were met? What would you be looking for in terms of demonstration that no further abuse is likely to take place in the broader legal terms that we're looking at: likely and reasonable and—

**Ms Schwartz:** I just wanted to add that one of the reasons we really would say an abuser is most likely to continue abusing is that the kind of education or counselling that a person would need to learn how to stop this has only begun to be researched. We really don't know how to correct the situation. It's not saying that never in the history of people will this situation change, but we've only begun to research how to deal with this, so we really don't know how to treat these people so that they'll improve.

We would look at the kinds of things we have here partly to see that this person has changed their own situation and own feeling so they won't continue to abuse and also partly to maybe put restrictions on their practice so they won't have the opportunities to abuse.

**Ms Christine Henderson:** If I may add, what you cannot do is irrevocably bar someone from the possibility of ever regaining the chance to practise their career again. While the ministry believes that the reinstatement conditions must, as far as it's practicable to do so, try to ensure that the person who is admitted back to the practice will do so safely and with the public's protection foremost in the minds of the college, there cannot be a complete prohibition for ever from practice, simply on the grounds of fairness and administrative law principles.

**The Acting Chair:** You wanted another question, Mr Owens?

**Mr Owens:** Just to take a slightly different tack: In terms of the minister's statement with respect to advocacy and support of complainants, this is an issue I've been working with since coming to this place; that is, the RHPA. This is clearly a concern of mine in terms of yes, we can set out this bill. In my view it's a reasonable bill that attempts to deal with some tough issues. My question, though, is that in terms of dealing with the complainants, what is the process or the system going to involve with respect to advocacy? Will there be a process for an advocate to be involved?

I couldn't find anything in the amendments. Is that something that will come in the regulations? Will there be, through the regulations, a duty placed upon the college with respect to the provision of advocacy, to the provision of materials in languages other than English

and French? What kinds of support will the colleges be mandated to give people?

**The Acting Chair:** Who'd like to try that one? Ms Schwartz, have you got any idea about that, or Ms Henderson?

1710

**Ms Schwartz:** I think it would be left to the college to determine how best to do that. One of the ways would be through the patient relations program, which actually has been in the RHPA since the RHPA was passed. It was added to the RHPA at second reading.

**Mr Owens:** I remember the debate that Wilson and I had about the patient relations committee.

**Ms Schwartz:** That's one of the things the patient relations committee is supposed to look at.

**Mr Jim Wilson:** It's "Mr" Wilson.

**Mr Owens:** Sorry, Jim.

**Ms Schwartz:** It's supposed to be reviewed by the Health Professions Regulatory Advisory Council, so that while it wouldn't come under regulations, it would certainly come under close scrutiny to see that they were doing things properly.

**The Acting Chair:** Anything further?

**Ms Christel Haeck (St Catharines-Brock):** Actually, it's on a similar point to the one Mr Owens raised with regard to the possible reinstatement of an abuser. I guess I can't say that in any nicer way.

I have had the opportunity in my constituency office to meet a patient who was abused and expressed a very serious concern about the fact that the particular practitioner had lost his licence once, in fact ended up being reinstated, and had abused again. You're not talking a single incident; you're talking a number of people who were abused by this particular practitioner, and the licence to practice has been removed. I can only tell my colleagues here that on behalf of that patient, there is a great fear that the person will be reinstated at some time and therefore will be able to do this again to other people.

I understand, Ms Henderson, that there is a range of reasons that you've expressed around the issue of someone—shall we say that there is some hope, however slim, of rehabilitation and that one cannot be barred for ever from his or her chosen career. However, if someone has twice in a 10-year period so seriously abused, and you're saying in five years' time this person could apply for reinstatement of his licence, I have some serious problems with that. I have some very serious problems with that, even realizing that it is rare—sorry for any psychologists who are here. I'm not a psychologist, but I would say that there is frequently debate within the psychological community about assessments as to the state of one individual.

You have here in the column "proposed government amendment" item (4): "proof to substantial degree of medical and psychological certainty of no future abuse." I'm wondering with what surety anyone can—and if you're only using one report, to what degree one can feel sure that someone who has done this dastardly deed would not be allowed to get out there and do it again.



**The Acting Chair:** You'd like to comment, Ms Bishop?

**Ms Bishop:** Yes. I'd like to point out in reference to the question that the CPSO task force did thoroughly investigate this area, and also in response to Ms O'Neill's question regarding the data and the seriousness of Ms Schwartz's statement, the task force did a very thorough check of the literature and of course talked to many experts in the field over the course of its work. They were, of course, totally independent of this government and relatively independent of the College of Physicians and Surgeons, and in fact they developed these criteria.

It's clear here that the onus is on the member who has lost his certificate of registration to demonstrate that he has been rehabilitated, and there are very stringent criteria for that, so that under this regime it will be difficult for an individual to be reinstated, although there will always be that possibility.

What we've seen in the cases that have reached the press lately has demonstrated that individuals have abused clients over a career and oftentimes it's only towards the end of their career, maybe because we're increasingly alert to this, that they are brought to justice. I think we're very aware that we don't want to revictimize other members of the public and allow this to continue.

**Mr Jim Wilson:** I just had a question that is in no way meant to be unfair, but with what we know about the extent of sexual abuse out there, would anyone have a guess—and I won't hold anyone to it—as to how many RHPA professionals might end up at the end of the day having their certificate of registration revoked?

**Ms Bishop:** I don't think anybody would have the faintest idea, fortunately or unfortunately. It's really hard to know. You can go on the data supplied by the CPSO, which is physician-based data, that suggest that somewhere around one in 10 physicians may be guilty of some form of sexual abuse, but that's the gamut. It's really hard to know how specific you could get, you know, how predictive you could be.

Then there are all the other health professions. They have a variety of relationships to their patients. Some have a very distant relationship, whether it's, say, fitting eyeglasses or something of that nature on a once-only basis or an ongoing psychotherapeutic relationship. It would depend on the nature of that therapeutic relationship as well.

**The Acting Chair:** Ms Schwartz, do you want to add something, please?

**Ms Schwartz:** Yes. We're also hoping that this legislation will change the statistics because more people will come forward to report, being aware of the problem, and hopefully fewer people will engage in this activity, being aware of the problem. Also, a person might be caught earlier, before they've gone on to do this with more of their patients. This legislation, we hope, will really change the situation. We really can't predict.

**The Acting Chair:** Anything further?

**Mr Jim Wilson:** No.

**Ms Bishop:** I just had one further point. I just thought of the report of the College of Physicians and Surgeons

of British Columbia, which I'm sure you're somewhat familiar with. We could in fact bring for the committee, if the committee desired, a synopsis of that report, which does delineate to a certain extent the nature of abusive relationships between different kinds of physicians, psychiatrists seeming to be at the top of the list of problems, unfortunately. We could bring that for your information if you would like that.

**Mr Jim Wilson:** I'd appreciate it, because in all the myriad of stuff we've read, I'm not familiar with that one, or it doesn't come to mind right away.

**The Acting Chair:** Ms Haslam, would you mind taking the chair so I could ask a couple of questions?

**The Acting Chair (Mrs Karen Haslam):** Are there any other further questions? The Chair recognizes Mrs O'Neill.

**Mr Jim Wilson:** Isn't there a conflict of interest?

**Mrs O'Neill:** Maybe a little bit. If I may go back to page 16, where we were talking at quite a bit of length about rehabilitation—I'm sorry; as you know, I haven't been part of the briefings and the work that you've done all summer—I thought I heard, as you went through that, 10 years somewhere. Was that one of the considerations?

**Ms Christine Henderson:** No, that's the length of time that information must remain on the college register made available to the public if in fact a member of a college has been found to have committed sexual abuse constituting either 1(3)(a), which would be physical sexual relations, or 1(3)(b), which would be touching of a sexual nature. The information must remain on the register and available to the public for 10 years if a panel of the discipline committee makes such a finding against a member.

**Mrs O'Neill:** Will the process be regulated for all of the colleges to have that process? I doubt they all have the process in place at this point.

1720

**Ms Christine Henderson:** Right. No, these statutory provisions would make that a requirement.

**Mrs O'Neill:** Okay. Now, if I may go to page 19, you did remove the "incompetent" and "incapacitated" as you worked your way through this. Would you like to make a comment about that for me, please, why you did that?

**Ms Christine Henderson:** One of the reasons was to focus upon sexual abuse of patients by members.

Professions also pointed out some practical difficulties with, for example, the issue of incompetence. A nurse observing a massage therapist may misinterpret what the practice of that profession really entails and may believe that the person was committing an act that looked like an act of incompetence in regard to a particular patient. The fact that designated acts of professional misconduct would have to be made by a college council, put in regulations, and that these provisions would have required the nurse to know what the designated acts of professional misconduct that would be reportable in the massage therapists' regulations would be, and across all of the professions—as a matter of implementation, it really didn't look like the kind of workable scheme that the ministry wanted this to be.



**Mrs O'Neill:** All right. If I may just follow that up, then, I know this bill is very specific in some ways. Is there going to be a mechanism or is there at the present time a mechanism for interprofessional reporting of incompetence, or is that always going to be impossible?

**Ms Christine Henderson:** Well, nothing would prevent a nurse from contacting the registrar at the College of Physicians and Surgeons and reporting a particular act performed by that physician.

**Mrs O'Neill:** So the mechanism is there at the present time?

**Ms Christine Henderson:** Yes, he or she could do that.

**Mrs O'Neill:** Okay.

**Ms Christine Henderson:** The mandatory aspect of that requirement has been removed.

**Ms Schwartz:** I just wanted to add that the mandatory aspect could be in time added if the college decided to make it a ground of professional misconduct. So there is that flexibility there for the future.

**Mrs O'Neill:** Okay. If I may go down to the bottom right-hand corner of page 19, regarding the exemptions, I'm having a little difficulty again because of not being part of the discussions regarding exemptions of these family members. Do you want to put that into context for me, please?

**Ms Christine Henderson:** The ministry is proposing to delete the ability of college councils to make regulations that would exempt any individual members from the reporting scheme. So these provisions would be struck out under a motion that has not yet been tabled, but the government intends to not support these provisions.

**Mrs O'Neill:** So in the bottom right-hand corner, you're saying those exemptions would not stand.

**Ms Christine Henderson:** That's right. There would be no exemptions to the requirement to mandatorily report sexual abuse of patients.

**Mrs O'Neill:** Okay. I guess page 20 was the same question.

On page 21, under the 30-day provision, there is an exception there, "reasonable grounds to believe." How serious would that have to be, or who is going to determine the reasonable grounds that this is going to happen and that 30 days is too long?

**Ms Christine Henderson:** It would have to depend, I would think, on the circumstances in the particular case that a reporter is met with. It's difficult to give you a specific in the absence of a factual situation, but I believe if there were any threat that the reporter believed might be there for that particular patient or other patients, the report should go immediately.

**Mrs O'Neill:** So you think the judgement would be made in favour of the reporter. I guess what I'm thinking about, and what Ms Bishop's alluded to, is that 30 days is a very short time in the business of quasi-judicial government, whatever you want to talk about, and I'm wondering if we're being realistic. I guess you're telling us that if there seems to be an emergency, so to speak, it would go in favour of the reporter, but then it's kind of

judging before the fact, which is always another problem.

**Ms Christine Henderson:** I think the reporter would also have to consider the fact that, as part of the report, the name of the patient is to go in if the patient consents. I believe one of the considerations given to permitting the 30 days to elapse was trying to work with that individual patient to get his or her consent.

None the less, the nature of the subject, namely an allegation of sexual abuse, is very serious. I believe it was felt that 30 days was a reasonable time to have elapsed to get that patient's permission or consent, but that there was an urgency around making such a report because it involved sexual abuse of patients.

**Mrs O'Neill:** I think this is relevant, and it'll be my closing remark. I understand at the present time the College of Physicians and Surgeons, if it is unable to obtain consent, keeps the report, and if it gets another complaint about the same practitioner, it informs the original complainant in case the person does not want to stand alone. I don't know whether that's what is envisioned here as well or whether that's just going to be part of the practice of that college.

**Ms Christine Henderson:** I'm not sure about the internal processes of the College of Physicians and Surgeons. It may be that as part of any college's investigation of a particular allegation, whether it be through an earlier report that did not proceed to discipline or simply through the investigatory process, other patients' names arise. It may be that patients are found, other individuals who may have been abused are located through the investigatory process, either through earlier reports or through the natural processes of investigation. That could very well happen.

**Mrs O'Neill:** That completes my questions.

**The Acting Chair:** Were there any other questions by any of the other members?

**Mr Grandmaître:** Yes. I want to go back to an earlier question by Ms O'Neill.

On page 19, you deleted clause 85.1(1)(c) and (d):

"(c) is incompetent; or

"(d) is incapacitated."

If I turn to page 21 and look at clause 4(4)(c), "an explanation of the alleged sexual abuse, misconduct, incompetence or incapacity..."

**The Acting Chair:** It's been struck out, Mr Grandmaître.

**Mr Grandmaître:** It's been struck out. Thank you very much. I've answered my question.

**The Acting Chair:** You are a wise man who can answer his own questions—or a fool, they say. Are there any other questions? Fine. Then do you want to come and close the meeting or do you want me to close the meeting?

**Mrs O'Neill:** I think I have some instructions. I don't know if we have the same ones.

**The Acting Chair:** To meet tomorrow at 3:30, and the committee is not meeting now, they're meeting later? Did I steal your thunder?

**Mrs O'Neill:** We have more, so I guess I should get in the chair and do it formally.

**The Acting Chair (Mrs Yvonne O'Neill):** I guess the instructions have changed since I was here at the last moment, but we will definitely have some decisions to make in this committee regarding the hearings and I understand we will be having the subcommittee meeting some time between now and 3:30 tomorrow afternoon,

when we will meet again. We have our list of presenters for tomorrow, and I hope we can start on time, because, as you know, there are far more presenters than are now slotted and your phones must be ringing, as are mine, and we would like to begin on time tomorrow, if possible.

With that, I adjourn this day's session of the social development committee.

The committee adjourned at 1731.







## CONTENTS

Monday 22 November 1993

**Expenditure Control Plan Statute Law Amendment Act, 1993; Bill 50, *Mrs Grier* / *Loi de 1993 modifiant des lois en ce qui concerne le Plan de contrôle des dépenses*, projet de loi 50, *M<sup>me</sup> Grier* . . . . . S-521**

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York North/-Nord L)

**\*Acting Chairs / Présidentes suppléante:** O'Neill, Yvonne (Ottawa-Rideau L); Haslam, Karen (Perth ND)

**Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry (Durham-York ND)**

**\*Owens, Stephen (Scarborough Centre ND)**

**\*Rizzo, Tony (Oakwood ND)**

**\*Wilson, Jim (Simcoe West/-Ouest PC)**

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Grandmaître, Bernard (Ottawa East/-Est L) for Mr Eddy

Haeck, Christel (St Catharines-Brock ND) for Ms Carter

Haslam, Karen (Perth ND) for Mr Hope

Wessinger, Paul (Simcoe Centre ND) for Mr Martin

#### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Grier, Hon Ruth, minister

Wessinger, Paul, parliamentary assistant to the minister

Bishop, Patricia, special assistant, policy

Henderson, Christine, legal counsel

Schwartz, Ella, policy analyst, professional relations branch

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Services



## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

## Official Report of Debates (Hansard)

Tuesday 23 November 1993

## Journal des débats (Hansard)

Mardi 23 novembre 1993

### Standing committee on social development

### Comité permanent des affaires sociales

### Regulated Health Professions Amendment Act, 1993

### Loi de 1993 modifiant la Loi sur les professions de la santé

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 23 November 1993

The committee met at 1604 in room 151.

REGULATED HEALTH PROFESSIONS  
AMENDMENT ACT, 1993

LOI DE 1993  
MODIFIANT LA LOI SUR LES PROFESSIONS  
DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 100, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 100, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen, and welcome to the second day of the standing committee on social development's review of Bill 100, An Act to amend the Regulated Health Professions Act.

Let me say at the outset that we will hear from all of the witnesses who are scheduled today for the time they had scheduled. I realize we're starting late because of a couple of votes in the House, but if you're scheduled for today, you will most certainly be heard.

Could I then call the representatives from the Ad Hoc Coalition of Regulated Healthcare Associations on Bill 100. As you are coming forward, we had one question.

**Mr Larry O'Connor (Durham-York):** As we're about to start the public hearing process on this very important issue, for clarification, in the wish to have this committee hearing proceed in an orderly fashion and knowing that we have very limited time to actually deal with all of it and hear from as many people as we would want to, I just wondered whether or not we are going to finish clause-by-clause by December 7, so that we can have this proclaimed along with the other regulated health professions.

My concern is that I know there are many committee members who would like to sit in the evenings, and unfortunately we aren't able to do that. Can we then at least let the very numerous people who would like to make a presentation, who aren't going to have the time—many of them will be victims—file a presentation with the committee so that we can have that on the record as we go through this process?

**The Chair:** Yes. As you know, the committee has been directed to hold hearings and discuss the bill until December 7. Those are the instructions that we're under, and I assume, unless we get different instructions from the House leaders, that's what we will do.

AD HOC COALITION  
OF REGULATED HEALTHCARE ASSOCIATIONS  
ON BILL 100

**The Chair:** At the beginning of this presentation, could I just indicate that the Ontario Society of Chiroprodists—I have learned how to say that; actually I take great pride and I'm going to say it again, the Ontario Society of Chiroprodists—and the Ontario Podiatry Association, which are the second and third presenters

today, have by letter indicated that their position is substantially that of the coalition. In order to provide time to discuss the position, in effect, of all three, they will have their time assigned to the coalition, but it is still the chiroprodists and the podiatrists who have that time.

With that by way of explanation, would you be good enough to identify yourselves for the members of the committee and for Hansard, and then please go ahead with your presentation. Welcome to the committee.

**Ms Signe Holstein:** My name is Signe Holstein. I am co-chair of the Ad Hoc Coalition of Regulated Healthcare Associations on Bill 100. I would like to introduce my colleagues to you. On my immediate left is Wendy Graham, a member of the Ontario Medical Association. On my far right is Pamela Fitch, a member of the Ontario Massage Therapists Association, and on my immediate right is Bob Haig, a member of the Ontario Chiropractic Association.

My day job, so to speak, is executive director of the Ontario Physiotherapy Association. Prior to taking my current position, I was a practising physiotherapist.

Physiotherapy is a hands-on profession in which touch is an essential element of practice. As a consequence, we took a major role in organizing the ad hoc coalition in order to help the entire regulated health care sector come to grips with Bill 100, its antecedents and its implications.

All associations representing health care practitioners to be regulated under the Regulated Health Professions Act were invited to join the coalition. Our submission to this committee is endorsed by 15 of the 24 associations that will be regulated under the RHPA.

Our coalition represents a broad range of health care associations, big and small; associations that are newly regulated and others that have been regulated for a long time; associations representing established professions and others representing relatively new professions. Together we represent over 50,000 practitioners and students across Ontario.

Each association recognizes that the professionals we represent have been slow in confronting and addressing the very serious issue of sexual abuse. Every association agrees with the objectives behind Bill 100. We agree that there is no place for professionals who exploit relationships of trust or their patients' vulnerability by sexually abusive behaviour. We agree that professionals must be encouraged to report incidents of sexual abuse. We agree that severe penalties are necessary to deter sexual abuse by professionals. We agree that funding should be available for the treatment of survivors of sexual abuse. We agree that more can be done to streamline the disciplinary process, to make it more effective and to increase the participation by victims and survivors.

With that as background, we'd now like to address the five specific issue areas addressed by our coalition,

beginning with the basic issue of the definition of "sexual abuse" in Bill 100. I would ask Wendy Graham to address this issue.

1610

**Dr Wendy Graham:** My name is Wendy Graham. I'm a practising family physician in North Bay. For the past two years, I've been immersed in the issue of sexual abuse by physicians.

The objectives and perspectives that I bring to this exercise are quite simple: There is no place in our health care system for practitioners who sexually abuse their patients. Practitioners found guilty of sexual violation or sexually abusive touching or who are repeat offenders of other forms of sexual abuse must be cast out of the professions. A practitioner who has, through inadvertence or insensitivity, used words and behaviours perceived as sexually abusive needs to be sensitized through education and commit to change their ways.

I've been asked to talk on behalf of the coalition about the definition of "sexual abuse" that obviously lies at the heart of Bill 100 and its effectiveness. The coalition has so many concerns about the definition that it is difficult to crystallize them in a short presentation, but I'll try my best.

We don't think that a single definition labelled "sexual abuse" which covers all types of abusive behaviour will work. Common sense tells us that sexual intercourse, sexual violation and sexual touching in a professional relationship are simply wrong. The difficulty arises with the subjective interpretation of remarks and behaviour in a practice setting. How do you differentiate between sexual inquiries that are offensive and those that are therapeutically necessary? How do you differentiate between remarks that are sexually abusive and those that are rude, offensive or simply misunderstood?

The coalition is also concerned that one definition cannot possibly capture the myriad of procedures and therapies conducted by over 70,000 regulated professionals and 24 regulated groups. How can a podiatrist be governed by the same definition that applies to a gynaecologist? How can a psychologist be governed by the same definition as applies to a massage therapist? In some professions touch can be banned outright; in others touch is clinically essential and a critical part of healing. In some professions remarks having sexual connotations can be banned; in others, such as psychotherapy, such remarks may be essential in obtaining relevant information to determine the appropriate treatment. How can one definition cover this wide range of circumstances?

Our concern is compounded by the ministry's desire to remove the clarification power contained in subsection (4). We think this power is absolutely essential to allow each college to adapt the definition to the circumstances and requirements of each profession. We do agree that the power to extend the definition by regulation is inappropriate and should be removed, but the power for each college to clarify the definition by regulation should stay.

Returning to the definition of "sexual abuse," however, we wish to point out that Bill 100 in no way addresses

the very difficult issue of consent. Is consent, whether real or inferred, a defence against a complaint of sexual abuse when occurring in a trust relationship? We think that no real consent exists in a practitioner-patient relationship and recommend that the legislation confirm that consent cannot be used as a defence, as a mitigating circumstance, in a charge of sexual abuse.

Bill 100 does not define what constitutes a patient or when a person becomes or ceases to be a patient for the purposes of Bill 100. Once again, defining when a person becomes or ceases to be a patient will vary across the gamut of health care professions, with a wide variation in ailments addressed and treatments provided.

Bill 100's definition of "sexual abuse" does not address the issue of intent. In some cases of sexual abuse, such as sexual violation, intent is unambiguous. Not so in the behaviour and remarks category. We are currently going through a revolution in social attitudes to sexual conduct and relations between sexes. We are also, particularly in metropolitan areas such as Toronto, having to deal with the increasing ethnic, cultural and religious diversities and traditions. We have to distinguish between conduct that is truly sexually abusive and that which is simply insensitive, annoying or rude. What is truly sexually abusive should be covered by Bill 100. What is insensitive, annoying or rude will in time be addressed through education, peer pressure and other types of formal sensitization.

The coalition feels strongly that a remark or behaviour that unintentionally causes offence should trigger sensitization through remedial training, not a complaint or a report of sexual abuse. We believe that an honest misunderstanding of what a practitioner intended by a remark should not necessarily result in a complaint or a report of sexual abuse, and I, as a patient, may choose to demand an apology from a practitioner as my full personal satisfaction to sensitize that practitioner about the impact of his or her conduct.

The definition of "sexual abuse" does not address the question of harm. In some categories of sexual abuse, such as violation, harm is clear. Not so with certain remarks and behaviour. If no harm is caused, should there be a complaint or a requirement to file a report? We think not. A complaint of sexual abuse will have a devastating effect on a practitioner, on the practice, her family and her standing in the community. Even if the practitioner is eventually cleared of wrongdoing, the stain of allegation will persist.

We have to recognize that the definition has to be, and be seen as, workable. It has to be clear. It has to be understood and interpreted by over 70,000 practitioners and 22 regulatory colleges representing 24 professions. It has to be understood by patients, employers and other third parties. It has to be reasonable and fair.

The coalition proposes a return to the three-part definition, as proposed by the government in Taking Action Against Sexual Abuse of Patients, to "sexual violation," "sexual transgression" and "sexual impropriety."

We also propose the introduction into the definition of what we call the exploitation formula first proposed by



the College of Physicians and Surgeons of British Columbia. This concept gets to the heart of sexual abuse. It is the exploitation of the patient's vulnerability and of the relationship of trust with the practitioner that defines sexual abuse. The exploitation formula also gets to the issue of intent, requiring wilful, knowing, abusive action by the practitioner.

Finally, the coalition proposes that the condition of harm be added to the sexual transgression and sexual impropriety categories.

The actual definition we propose is set out on page 24 of our submission. Lest anyone suggest that what we have done weakens Bill 100, I say to you it does not.

The Minister of Health has said Bill 100 is designed to punish practitioners guilty of sexual abuse. The coalition believes that the proposed amendments add clarity; will encourage, and not discourage, reporting; and will assist in enforcement.

The Minister of Health has said that Bill 100 is designed to deter abuse. The penalties contemplated by Bill 100 will do that: the fine up to \$35,000, potential loss of licence, payment of the costs of the victim's counselling and therapy, and reimbursement of the college costs for legal fees, the investigation and disciplinary process.

It is important that the committee recognize that the coalition does not argue or question these penalties. Severe penalties will be a major deterrent. We don't want to reduce the deterrent factor, nor do we wish to claim that these penalties are excessive for those who are actually found guilty of sexual abuse. They are not.

I'd like to turn things back to Signe.

1620

**Ms Holstein:** I have been asked to address the second issue on the coalition's agenda, mandatory reporting of incidents of sexual abuse by practitioners. Under Bill 100 as drafted, a health care practitioner who has reasonable grounds obtained in the course of practising the profession to believe that another regulated health care practitioner has sexually abused a patient must file a report. The report is to go to the registrar of the college to which the abusing practitioner belongs. A practitioner who fails to make a report may be subject to disciplinary action herself.

Historically, incidents of sexual abuse have been underreported. Underreporting is the fundamental problem in deterring sexual abuse, in identifying abusive practitioners and in correcting abusive behaviour. How effective Bill 100 is will depend to a considerable extent on the degree to which practitioners respond to incidents of abuse by other practitioners.

In our submission, at page 27, we refer to the state of Minnesota, where mandatory reporting is imposed as a condition of licence. Reports of breach of practice standards have actually fallen since mandatory reporting has been introduced, and there have been no reports of sexually abusive words used by practitioners since mandatory reporting was introduced. The coalition is concerned that mandatory reporting requirements, if not handled properly, will result in fewer challenges to

sexually abusive behaviour than occur now.

How do we propose to improve Bill 100? Practitioners are more likely to report incidents of apparent sexual abuse if it is completely clear when they are supposed to report and if practitioners believe that the consequences of a report are an appropriate and balanced response to the incident; if the punishment fits the crime, so to speak. If both of these criteria are not met, underreporting will continue. Let me explain why.

First, Bill 100 is not clear as to when a practitioner should report. What does "in the course of practising the profession" mean? What constitutes "reasonable grounds"? Does hearsay evidence constitute grounds for a report? Does the practitioner have to interview the practitioner and patient in order to put the incident in context? Does there have to be a patient-practitioner relationship with either the victim or the practitioner to trigger a report?

Second, practitioners will have difficulty accepting that Bill 100 puts in place balanced and appropriate investigative and disciplinary processes to handle reports of sexual abuse, a process that is fair and observes and protects the civil rights of both the accused and the complainant.

Third, what happens to a report? It seems that total discretion is left to the college. Uncertainty about what a college will do with a report, how, why or when the college might respond, will militate against reporting.

The problems will be particularly acute for practitioners in one profession judging the actions of practitioners in another profession. Bill 100 assumes a high level of awareness by one profession of the treatments and procedures of another. This, quite frankly, when you're dealing with 24 health care professions, is unrealistic.

Should a physiotherapist, someone from my profession, be required to judge whether the remarks of a psychologist constituted sexual abuse? Should a psychologist be placed in the position of judging whether the touch of a massage therapist constituted sexual abuse?

The coalition is very concerned that Bill 100's mandatory interprofessional reporting requirements will have two alternate results, both equally bad: either chronic underreporting due to uncertainty or excessive reporting that clogs up the disciplinary process. On the latter possibility, many coalition members fear that Bill 100 will generate well-intentioned but unwarranted interprofessional reporting of practices that are completely acceptable and have proven therapeutic value in other regulated professions.

Mandatory reporting by treating professionals is another area of grave concern to the coalition. If one professional comes to another for treatment and during that treatment discloses one or more incidents of sexual abuse, Bill 100 would bind the treating practitioner to make a report.

In addition to breaching the long-accepted rights of patient-practitioner confidentiality, we are very concerned that this will result in professionals avoiding self-referral for treatment of abusive or other aberrant behaviour. This is obviously counterproductive to the objectives we all

share, those being to identify and correct abusive behaviour.

Finally, the coalition is concerned about the obligation to file a report if the alleged victim refuses to consent to such a report. Doesn't this simply perpetuate the victim's powerlessness in the face of the system, and what does it achieve? An alleged victim who refuses to consent to a report cannot be expected to assist with any investigative and disciplinary process, which likely means, assuming the abuse occurred, that the incident is not effectively addressed.

Our proposed solution which goes hand in hand with the coalition's recommended approach to the definition of "sexual abuse" is to give some latitude to professionals in the reporting of incidents of sexual impropriety. This latitude would apply only to the category that we refer to as sexual impropriety. Mandatory reporting would continue in the sexual violation category and, with great reluctance but in an attempt to achieve consensus, coalition members have agreed to mandatory reporting in the touching category but warn that this will inevitably be problematic.

We call our proposal the duty to intervene. In essence, it statutorily obliges the practitioner to respond in a way appropriate to each individual situation from a series of actions listed in the statute. Those actions are of increasing severity and include but are not limited to making a report of the incident. The practitioner could select any or all of these actions in response to the circumstance of each event. The actual wording of the amendment we propose is set out on pages 24 and 25 of our submission.

We think this approach will be far more viable in deterring and addressing sexually abusive behaviour in the behaviour and remarks category.

We also propose removing the phrase "has reasonable grounds" and the phrase "in the course of practising the profession." The coalition believes that a practitioner should respond to an incident of sexual abuse or sexually abusive behaviour wherever or however that practitioner becomes directly aware of the incident or the behaviour, and the only criterion should be if the practitioner believes the incident occurred.

I would now ask Bob Haig to address the next issue.

**Dr Bob Haig:** My name is Bob Haig. As Signe would put it, in my day job, I'm a practising chiropractor, and I chair the RHPA committee of the Ontario Chiropractic Association.

Like physiotherapy and massage therapy and other professions that are members of the coalition, chiropractic is a hands-on profession relying primarily on manipulation and physical treatment of the neuromuscular-skeletal system.

Virtually every patient interaction involves skin-to-skin contact of some kind, so for professions such as ours, there is considerable scope for honest misunderstanding both by our patients and by other health care practitioners unfamiliar with our treatment techniques and procedures.

Bill 100, as drafted, alarms us because we see it creating the potential for misinformed reports and complaints, and as both Signe and Wendy have said, once a

complaint of sexual abuse is made, whatever the outcome of the disciplinary process or investigative process, the result for the practitioner is devastating.

However, I've been asked today to speak about two rather technical but important issues raised by Bill 100.

The first is intervenor status or what is referred to in section 7 of the bill as non-party participation in the hearing of complaints of sexual abuse by the regulatory colleges.

There are two types of intervenors to consider. The first and most important is the complainant. I have an association background, and I must say I was a little surprised to learn that college disciplinary proceedings view complaints as being a matter between only the college and the accused party, that the complainant is technically not a party to the proceedings.

The coalition understands and accepts that this is the case, that in a self-governing scheme disciplinary proceedings are a matter between a college and the member. But we also understand how the college disciplinary system appears to victims and survivors to minimize their impact on the proceedings, so we agree with the victims and survivors that much more should be done to both allow and encourage their participation if and when they choose to participate in the investigative and disciplinary process.

The second type of intervenor is persons or groups who represent neither the complainant nor the accused. We've called such people or groups third-party intervenors.

Bill 100 does not describe the role such third-party intervenors might be expected to play, and it gives absolute discretion to the disciplinary panel to grant leave to such third parties to have standing. It's in this respect that we believe Bill 100 has gone too far.

#### 1630

We're concerned that panels will cave in under pressure and allow multiple intervenors in inappropriate circumstances. Multiple intervenors can be used as a cynical strategy to delay disciplinary hearings and add to their cost unnecessarily, or to doubleteam either the complainant or the accused practitioner. Justice is not served by such strategies. In fact, doubleteaming obviously serves to simply perpetuate the victimization.

The coalition is also concerned that in the absence of firm statutory guidance, multiple third-party intervenors will almost certainly generate court challenges by the accused, in some cases simply delaying the disciplinary process but in others resulting in decisions being overturned. In the coalition's view, the legislation should not leave this excessive latitude for the reversal of decisions on technical or procedural grounds, with the potential of letting the guilty go unpunished.

We propose that Bill 100 restrict the participation of non-party intervenors to those persons who satisfy the accepted legal test in this area of law: the test of relevant interest. This test is satisfied where the disciplinary committee, after that panel makes a determination of guilt in a particular case, accepts that the witness will assist the panel in assessing the emotional or physical damage



sustained by the victim or will assist the panel in determining the appropriate penalty or penalties following a finding of guilt and in light of the harm caused in the particular circumstances at play. Our legal advice is that this test of relevant interest will mean fewer appeals on technicalities and a stronger guarantee that findings of guilt against offending practitioners will be upheld.

The second issue area I've been asked to speak to goes to the heart of Bill 100. As everyone here is aware, Bill 100 has been structured as an amendment to the Regulated Health Professions Act that was passed by this Legislature in November 1991 and is scheduled for proclamation by the end of this year.

We understand why the government decided to graft sexual abuse legislation on to the RHPA. It's easier. It makes use of an existing statutory and regulatory framework and simply expands that framework incrementally, instead of starting from scratch, to cover sexual abuse. But that grafting approach creates a number of anomalies and problems. Signe and Wendy have already mentioned several. Let me just summarize.

It means that only the health care sector is covered, in spite of a tide of evidence that sexual abuse of trust in unbalanced power relationships is not restricted to the health care sector.

It also means that only the regulated health care sector is covered. The large and growing unregulated health care sector, where substantial potential for sexually abusive conduct exists, is left untouched.

The ministry states that Bill 100 can apply only to the regulated sector because only that sector has the existing procedures to handle complaints. But that conundrum has been created only by the ministry's decision to attach Bill 100 to the RHPA and to use the RHPA's regulatory structure.

Finally, this grafting approach, we fear, means that Bill 100, once passed, will effectively be cast in stone. It will remain unchanged and unchangeable, even in the face of practical experience, changing circumstances and requirements, because the government or the Legislature will be reluctant to reopen the omnibus and complex RHPA in order to amend only those parts dealing with sexual abuse.

The coalition believes it is absolutely essential that Bill 100 be opened to periodic review and refinement, and as part of the RHPA we simply don't think that's likely to happen.

There are a number of alternative approaches that the coalition considered in trying to get around these problems. In the end we decided to propose that Bill 100 be severed from the RHPA and restructured as standalone legislation.

We are prepared to accept, for the time being, the application of Bill 100 to the health care sector only, and perhaps only to the regulated sector, as a first step. But we think it crucial that the scope of Bill 100, as a standalone statute, be incrementally expanded to cover sexual abuse by provincially regulated professionals in all sectors where unbalanced power relationships and relationships of trust between client and professional exist.

Legislation that addresses only the regulated health care sector is tokenism. It makes an inference about conduct and standards of professionals in the regulated health care sector that is manifestly unfair and offensive. It also addresses only one small segment of the society-wide problem of sexual abuse.

I would now turn the presentation over to Pam Fitch.

**Ms Pam Fitch:** Thank you. I am here as president of the Ontario Massage Therapist Association. I am a registered massage therapist in private practice in Ottawa. It's a privilege to be able to speak to this committee as part of the ad hoc coalition of regulated health professionals.

Massage therapy is one of the few professions where touch is integral to achieving client health and wellbeing. Unlike several of the other colleges, which have strict codes against touching patients, massage therapists use their hands to heal. Like physiotherapists, we are a predominantly female profession. Many of us work directly and intentionally with survivors of sexual abuse so that they may reclaim their bodies and be empowered to decide how and when they want to be touched. It's an extraordinary experience to witness the healing in a client as they progress from victim to survivor.

Massage therapists support the objectives of Bill 100 and urge that action be taken to address sexual abuse by professionals in all positions of authority, power and trust. Having seen the enormous potential for change that appropriate therapy for sexual abuse can offer a victim, we believe that each survivor should have the right to heal.

I've been asked to present the coalition's position on the therapy and counselling fund referred to in section 85.7 in Bill 100. This is a highly contentious and sensitive subject and has been the topic of a great deal of debate at our consultations with victims and survivors and their representatives.

I think, to begin with, we have to get straight what each college's therapy and counselling fund is for. It's not for victims and survivors to obtain damages, compensation or restitution. If that's what a victim or survivor needs, that person is in no way precluded from taking civil action against the practitioner or seeking compensation from the Criminal Injuries Compensation Board.

Bill 100's therapy and counselling fund is designed to pay the survivor's costs for therapy and counselling relating to the incident of sexual abuse that triggered the complaint to the college. While disbursements from the fund should be conditional on a determination of guilt by a disciplinary panel, the coalition believes that the funding should be retroactive to cover all counselling and therapy received as a result of the incident. The coalition recognizes that counselling and therapy will often be required to get the victim to a point where he or she can make a complaint and to prepare the victim for the investigation and disciplinary process. Such treatment should be covered by the fund, assuming that a determination of guilt is in fact made.

On the other hand, the coalition is strongly opposed to the notion that funding should flow even if the panel's



determination of guilt is appealed. Whether an appeal is based on fact or procedure, an appeal is an appeal. The ministry argues that appeals can be made on a range of grounds, not just the finding of guilt. The ministry also argues that if a guilty verdict is overturned on appeal, the college could go after the victim for repayment.

If a panel decision is overturned on appeal, it is completely unrealistic to think that any college would try to reclaim the money that had flowed from the fund during the appeal period. Furthermore, our lawyers tell us that it is impossible to try to draft legislation that somehow distinguishes between the types of appeal, other than the basic distinction between law and fact or the merits of an appeal.

The coalition is also very concerned about the fund being used to cover the cost of treatment by unregulated health care practitioners. In the unregulated sector there are few, if any, standards of practice, accountability, and mechanisms or malpractice insurance to cover misadventures. In the unregulated sector, in our view, there is simply too much potential for treatments that at a minimum may be ineffective and at worst will be counterproductive, perhaps further risking the health of the patient.

In the unregulated sector, there's even more potential to encounter sexually abusive behaviour, thus continuing the victimization of the survivor. The government, in its amendments listed in the Consolidated Report dated November 4, 1993, appears to recognize these dangers. One proposed amendment calls for the survivor receiving the funding to sign a document indicating that he or she understands that the therapist or counsellor is not subject to professional discipline. Since these problems of referral to the unregulated sector are acknowledged, we ask, why should Bill 100 allow for referrals to the unregulated sector at all?

#### 1640

Another very serious concern relating to the therapy and counselling fund is how it is to be financed. The coalition has serious reservations about each fund being financed by the members of each college. To us, this represents an unwarranted erosion of the basic principle of government-funded, universally available, no-fault health care entrenched in the Canada Health Act and the Ontario Health Insurance Act that is basic to our system in Ontario.

We're also worried that if financed by additional levies on members, the capacity of each fund will vary widely from profession to profession or that the burden of financing each fund will be felt much more heavily in some professions than others. The larger professions will be able to finance a relatively large fund and the additional financial burden on individual practitioners will be marginal. For the smaller professions, establishing a fund of reasonable capacity will require a much larger individual financial contribution. It is precisely those smaller professions such as mine, massage therapy, that feel the most vulnerable under Bill 100 and that, because of the average income of our members, are least able to sustain the additional burden of supporting the fund.

Our concerns are magnified if the ministry persists in

its recommendation that each victim have an absolute entitlement to the full \$10,000 if there is no statutory time limit on complaints and if funding continues to flow regardless of an appeal from a panel decision. I tell you in all candour that there are many in my profession who won't bear the additional financial liability and exposure contemplated by Bill 100. They will leave regulated practice and move into the unregulated sector. I suggest that this would be the case for any professional who can continue to practise without much of an adjustment in the unregulated sector. If significant numbers of regulated health care practitioners make this move, we will undercut the basic principles and objectives behind the Regulated Health Professions Act.

In regard to the fund concept as contemplated by Bill 100, we are worried at the evident or perceived conflict of interest of each college determining guilt and controlling disbursements of the fund. We also think that fines paid by practitioners found guilty of sexual abuse should be paid into the college fund, not into the general government revenues.

Finally, and this is a consistent theme for us, we think that funding should be available to cover the costs of counselling and therapy for victims of sexual abuse wherever that abuse occurs in unbalanced power relationships or in trust relationships, not just in the regulated health care sector.

To summarize the coalition's recommendations relating to the fund, we think that there should be a single fund, financed from government revenues; that allocations from the fund should be administered by one independent expert board after a finding of guilt by a college; that funding should be retroactive to the incident of sexual abuse; that the fund should be expanded over time to cover the cost of counselling and therapy for survivors of sexual abuse by all provincially regulated professionals where unbalanced power or trust relationships exist; and that fines should be paid into the fund, not into general government revenues.

That concludes our formal presentation, but let me quickly emphasize three key points: We recognize that sexual abuse is a problem, we're doing our best to confront the problem, and we want to be a partner in the solution.

Legislation alone is not enough. We need ongoing consultation, education and communication which involves victims and survivors, practitioners, associations, regulatory colleges and the broad spectrum of health care consumers. The legislation itself must be open to regular improvement as we learn more about the problem and how to respond. Finally, to work, this legislation must be, and be seen to be, a fair, appropriate and balanced response to the problem and one that preserves the civil rights of both the complainant and the accused.

Thank you for your attention.

**The Chair:** Thank you for a very thorough presentation. We are tight for time. I will allow one question from each caucus, beginning with Mr Wilson.

**Mr Jim Wilson (Simcoe West):** Thank you very much for your presentation. One question is not nearly

enough to cover all the points. Perhaps I should have time to think of my one question.

There have been some changes since your brief was sent to us, and one of those big changes was with respect to mandatory reporting. You've had a chance to see those in the November 4 document. Were any of the new amendments of some help?

**The Chair:** Just so we're clear on what you're referring to, because I'm not sure whether those amendments have been tabled—

**Mr Jim Wilson:** Is that right?

**Mr Paul Wessinger (Simcoe Centre):** Yes. That's the one I think you've heard about, the diversion and remediation, where the college has the right to assess.

**Mr Jim Wilson:** No. Mr Chairman, could I just pass at this time until I can formulate the question? I didn't know we just have one, and I have nine questions written down.

**The Chair:** I apologize. It's simply the time and trying to make sure we hear from everyone who is slotted in today. I'll come back.

**Mrs Karen Haslam (Perth):** The trouble is that I have two comments and one question. One of the comments is that we looked at the definition of "harm." May I say I'm a strong person and I come from a strong family, as you do, obviously, and I could probably handle turning to a person and saying, "Get your hands off me, you sleazebag." But there are people out there who come to a doctor in an illness situation, so the definition of "harm" I don't think is the same for someone who may not have as strong a personality as myself or my daughter. That's one comment I'd like to put out.

The other one was the skin-to-skin contact. I've gone to chiropractors and I appreciate the relief and the treatment, but let me tell you, I can tell the difference between skin-to-skin contact.

Pam, you were talking about the referral of counselling services to unregulated. I would like to draw your attention to the victim in this. That victim has come to a regulated person; that victim's trust has been violated. I can see why offering them another avenue would be helpful to them in their recovery, because there was a loss of trust and a distrust of some of those people. If as a victim they want to take counselling at another area, I feel we should allow that. Where else would they go, if they didn't trust the professional they've already been to?

**Ms Fitch:** I think you will find, or we have found at any rate in our consultations in the 24 health professions, that there has been significant education and training of the health professionals who would be in place to deal therapeutically with survivors.

**Mrs Haslam:** I'm dealing with a victim's point of view; as a victim.

**Ms Fitch:** I can appreciate that there might be some hesitation to going to a regulated health care practitioner, but I would hope that under this new legislation there would be greater protection for the individual with a regulated health care practitioner than with someone from whom there is no recourse, no malpractice insurance, no

means to follow up on any subsequent abuse, with an unregulated health care practitioner.

1650

**Mrs Haslam:** But the regulation states that the only criterion was that they were not accused or convicted of that assault.

This is going to be a very difficult committee when the time lines are this short.

**The Chair:** It is, but I'm afraid as Chair I'm trying to be fair to everyone. Ms O'Neill.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** That's a very helpful presentation you've just given; you've covered an awful lot. I'd like to ask one question on the mandatory reporting. I want to refer to page 29, "Pursuant to the coalition's proposed amendments, a list of responses of increasing gravity would be set out in the statute." I haven't had a chance to peruse all of this brief, so do you want to say a little more about that and who would make that decision? I haven't had a chance to examine your proposed amendment in this area. I wonder if you could explain a little more about "responses of increasing gravity."

**Ms Holstein:** If you go into the amendment itself at the bottom of that page and the top of page 30, the suggestions are that it might range from meeting the member to admonish that member, professional to professional—

**Mrs O'Neill:** That would be within the same profession?

**Ms Holstein:** Or another profession. We recognize that with uneven balances of perceived power in working relationships among health care professionals, that might be a contentious issue as well. But I would remind you this was a coalition agreement, that it might mean assisting the patient or the client in approaching the practitioner directly, providing them with that support. It might be to advise the patients of their rights to go forward to the appropriate college, how that might be done and what supports are required, or it might mean in the end filing a report with the appropriate college. It starts very simply.

**Mr Jim Wilson:** The reason it's difficult to phrase a question with respect to mandatory reporting is my reading of your brief and your oral presentation. In this particular area, you're at the other end of the spectrum, as it were, in terms of what you're proposing and what the amended version of the bill now contains. I just want to give you an opportunity to once again try to convince us that your proposed amendments are the way we should go. I'll tell you I have some problems with your proposed amendments on pages 29 and 30 of your brief. It seems to me they're fairly weak, and that's why I say it's the other end of the spectrum from the bill itself.

Secondly—I'll make it a two-part question—I don't think the government, to be serious, is going to budge in its definition of "sexual abuse." One of the things they've tried to do is with respect to the "behaviour or remarks" section, which is 3(c), that there can be a different sanction for that. I was wondering if that was of any help. In other words, later on in the bill it says that under



that category of sexual abuse, it doesn't mandatorily go to discipline, that there is some flexibility now built into the amended bill. Your comment on both of those, please.

**Ms Holstein:** In terms of the mandatory reporting, the recommendation that the coalition is making applies to remarks and behaviour only. We're not suggesting that it applies to the other aspects of sexual abuse.

**Mr Jim Wilson:** So mandatory reporting in (a) and (b), but (c) is—

**Ms Holstein:** But (c) is a duty to intervene. We don't see that as weakening the bill.

**Mr Jim Wilson:** Okay. I misunderstood that.

**The Chair:** Thank you very much for coming before the committee today.

#### ONTARIO PHYSIOTHERAPY ASSOCIATION

**The Chair:** We'll move on to the representatives from the Ontario Physiotherapy Association. While those representatives are coming, I'll remind the members of what the subcommittee has discussed. Given the tight time lines, if there is time for one question I will move in rotation among the parties, but there will not necessarily be time for a question by all three caucuses, and I will have to be very strict on that. I apologize, but it's the time. We will begin with the official opposition.

Welcome to the committee. If you'd be good enough to introduce yourselves, please go ahead with your presentation.

**Ms Beverley Lafoley:** Mr Chairman, committee members, good afternoon. My name is Beverley Lafoley and I am president of the Ontario Physiotherapy Association. I am a licensed physiotherapist practising in Sudbury, Ontario. With me today is Cheryl Kirkness, a physiotherapist practising in a rehabilitation setting in southern Ontario.

The Ontario Physiotherapy Association represents about 2,800 physiotherapists in the province. As a predominantly female profession, we understand the impact of power in relationships, particularly in the health care sector. Physiotherapy is essentially a hands-on profession. Whether assessing or treating a client, we place hands on the patient's body to guide, to stabilize or to produce or to resist movement. This is an essential element of our profession.

We strongly support the development of legislation that will eradicate sexual abuse from the health care system and we want to assist in developing Bill 100 into legislation that will be effective, efficient and capable of empowering victims without compromising the rights of the innocent.

Bill 100 will have a direct and major impact on the practice of physiotherapy in this province. As a result, the Ontario Physiotherapy Association took a major role in organizing the ad hoc coalition of regulated health care practitioners and has cooperated in the development of a response to Bill 100 that has been presented to you today.

It is not our intent today to repeat the coalition's analysis or recommendations but to confirm our support for those recommendations. However, we would like to identify certain issues raised by Bill 100 of particular

concern to physiotherapists in our practice. Cheryl will outline some of those concerns.

**Ms Cheryl Kirkness:** First, my apologies for the voice that's coming out of this body.

In terms of the first of the concerns, the definition of "sexual abuse" as drafted causes a great deal of concern for physiotherapists. The language, particularly that in clauses 3(b) and 3(c), is ambiguous and open to considerable interpretation in the practice of physiotherapy. As we understand it, the definition means that any touching or remarks of a sexual nature could be deemed sexual abuse. There are many situations where a physiotherapist, in providing appropriate, accepted and effective treatment, is involved in activities which could be interpreted as touching of a sexual nature. Let me give you a few practical examples of these situations.

Consider a female physiotherapist assisting amputees in preparing for and learning how to use a prosthesis, including appropriate methods for putting the prosthesis on. When the patient is a male above-knee amputee, this may involve handling of the male genitalia to ensure that they are not pinched in the prosthesis.

Consider the example of a male physiotherapist treating a female patient with a chest problem. In providing chest physiotherapy to a patient, physiotherapists may use percussion over the chest wall. This may require that the physiotherapist's hands repeatedly come in contact with the woman's breast, the necessary location for percussion if the treatment is to be effective.

When treating a patient, male or female, with a back problem, palpation of the symphysis pubis, which is located just above the genital area, may be an important component of the initial assessment.

In fact, many of our manual therapy techniques and neurological facilitation techniques require the physiotherapist to use her hands, arms and sometimes her body to stabilize a particular area in order to provide the most effective treatment.

In all of these cases, the physiotherapist could technically be charged with sexual abuse because she or he has used touching of a sexual nature. Alternatively, another professional unfamiliar with physiotherapy treatment procedures could feel compelled to file a report.

One of the things we learned in working with the coalition and in meeting with survivors is how easy it is to misunderstand and misinterpret hands-on treatment. The consequences of honest misunderstandings are grave and are of considerable concern to us.

#### 1700

I also note that we have concerns about the definition of "remarks of a sexual nature." It is a normal practice in physiotherapy to provide advice regarding positioning for sexual intercourse as part of the comprehensive treatment of an individual with back pain following hip or knee surgery etc to prevent unnecessary discomfort or injury. For the patient with a significant disability, such as the spinal-cord-injured patient, concerns regarding sexual relationships are extremely important and are frequently raised with the physiotherapist. In all of these situations there is a potential for misunderstanding.



We do not want legitimate concern on the part of a physiotherapist regarding the potential for a complaint of sexual abuse to result in the modification of a treatment approach to something less complete or appropriate. We also do not want charges or reports of sexual abuse arising out of honest misunderstandings to absorb college review time when they should be dealing with genuine and serious offences.

The Ontario Physiotherapy Association supports the concept of "exploitation" as a necessary component of the definition of "sexual abuse." We believe that this concept will serve to prevent inappropriate cases, such as the examples cited, from being reported while acknowledging that sexual offences can and do occur in any of the three categories of definition.

The second issue we would like to discuss is the approach to mandatory reporting as outlined in Bill 100. The realities and complexities of the health care environment in which we practise lead us to believe that mandatory reporting of all types of sexual offence will not be effective or workable. We support the recommendations outlined in the submission of the Ad Hoc Coalition of Regulated Healthcare Associations on this issue. We would like to add a few comments.

We are concerned that as a hands-on profession, we will be particularly vulnerable to reports by other health care professionals who do not understand and cannot realistically be expected to understand our treatment procedures. The examples I use to illustrate our concerns with the definition apply equally in this context.

We are concerned with physiotherapists being required to report when the patient doesn't want the report to go forward. Doesn't this simply perpetuate the powerlessness of the victim and his or her victimization by the system? We are concerned about what our college will do with these reports and the potential for huge variations from college to college.

Assuming that the definitions are clarified, the Ontario Physiotherapy Association supports mandatory reporting as a necessary response to sexual violation. However, we believe that the concept of duty to intervene as proposed by the Ad Hoc Coalition of Regulated Healthcare Associations is the most appropriate way of dealing with situations involving the use of language and behaviour and touching.

We believe that this will ensure that the issue is addressed, appropriate reports and complaints go forward to the college and the college will focus on the complaints where the victim most needs its intervention.

**Ms Lafoley:** As I noted earlier, the commitment of the Ontario government to legislate against sexual abuse in an unbiased and effective manner is strongly supported by the members of the Ontario Physiotherapy Association. Abuse or exploitation in an unbalanced power or trust relationship is not to be tolerated and must be deterred.

As a predominantly female profession, we are keenly aware of and sensitive to the issues related to sexual offences. We agree that there is no place in our profession for physiotherapists who exploit relationships of

trust or the vulnerability of their patients by being sexually abusive.

We agree that professionals must take the responsibility to report incidents of sexual abuse. We agree that severe penalties are required to deter sexual abuse by professionals. We agree that the disciplinary process needs to be streamlined to make it more effective and more accommodating for the victims and survivors.

While we strongly support the principles addressed in the bill, we fear for its potential implications on the caring and physical components of our practice if the bill passes as is.

With an issue of such scope and complexity, it is essential that legislation strike an appropriate balance in safeguarding the rights of both the accused and the accuser. It is essential that legislation encourage professionals and victims to report such abuse. However, it is also essential that the legislation is workable in our complex health care environment.

We have presented our concerns to you. We ask that you give careful consideration to the difficult but necessary changes that need to be made to this legislation to ensure its effectiveness.

**Mrs O'Neill:** I want to go back to page 4, which you didn't bring forward in your actual presentation, but which I think is very important because at one time in the legislation we were talking only about reporting those people for whom we could establish a name or an identity. You've stated a very practical problem within the hospital setting. I think it would be important that you put some of that on the record that you have not been able to give us, because I really do think identity is important in this issue of mandatory reporting. Could you say a little bit more about page 4?

**Ms Kirkness:** Certainly, I'd be happy to if the voice holds out. A real concern we have, for instance, is identified by an example in the acute care hospital. As it stands right now, for a practising therapist going up on the wards of an acute care hospital, the patients often interact with you because you spend a fair bit of time with them. In doing that, they're often telling you about what's happened during the day, particularly if it occurs with some difficulty earlier in the day regarding another practitioner. That person might not be identifiable. If this is a concern regarding sexual abuse, it would be my responsibility as a physiotherapist to try and find out who that was, and that will lead to a great deal of difficulty.

Currently, working in a rehabilitation setting, the number of nurses who are involved with the patients I treat are much fewer than in an acute care hospital, and in discussing details regarding a situation with one nurse, patients still have difficulty identifying to me who that nurse is. So there remains that problem.

Likewise, I am often called "nurse" or "doctor" if I go up on a ward. Obviously, that's a misinterpretation, but if we all look the same in a lab coat, it's an understandable misinterpretation. You have to be cautious about inappropriate reports being made against the wrong professional with the best of intentions by both the patient and another professional involved.

**The Chair:** Thank you very much for coming before the committee this afternoon.

ONTARIO PSYCHOLOGICAL ASSOCIATION

**The Chair:** Perhaps I could call on the representatives from the Ontario Psychological Association.

**Mr Jim Wilson:** Mr Chairman, as the presenters are coming forward, I want to state on the record that the committee hearings being crammed in such a short period of time is really quite difficult, given that we're not able to explore issues as fully as they should be. I just want to express my disappointment at this time.

**The Chair:** Thank you.

Welcome to the committee. Perhaps you would be good enough to introduce yourselves for Hansard.

**Mrs Haslam:** Mr Chair—

**The Chair:** I'm sorry, we really must move on. Please introduce yourselves and go ahead with your presentation.

**Mrs Haslam:** This is a clarification.

**The Chair:** Okay. Let's let them and we can come back. Please go on.

**Dr Ruth Berman:** Mr Chairman and members of the committee, I'm Ruth Berman, executive director of the Ontario Psychological Association. With me are Drs Iris Jackson and Carole Sinclair. Dr Jackson is past president of our association. She is in full-time, independent practice in Ottawa and is the former chair of our ethics and policy committee. Dr Sinclair is director of treatment services at the Dellcrest Children's Centre in Toronto. She is a member of our current ethics and policy committee and is the coauthor of the Canadian Psychological Association code of ethics, our national code.

Thank you for this opportunity to speak to you about Bill 100. The Ontario Psychological Association is the professional association that represents the psychology profession in Ontario. Our approximately 1,400 members work in a variety of practice settings, providing a range of diagnostic, therapeutic and preventive services.

As a professional community, we have long been concerned about the sexual abuse of clients by psychologists and other professionals. We have been active in studying the problem, in educating ourselves and the public about the problem, in treating those who have been abused and in encouraging the development of ethical codes and standards to prevent such abuse from occurring.

We have appended to our written submission, for your information, the current ethical and relevant standards of our members, the research findings related to the incidence and reporting of sexual abuse by psychologists, as well as a bibliography of the studies undertaken by psychologists in this problem area.

1710

Our profession well understands the devastating impact of sexual abuse.

Many of our members work with clients who have experienced sexual abuse in their lives. We are totally committed to a policy of zero tolerance and support the need for effective legislation to prevent the occurrence of

sexually abusive behaviour by professionals.

The Ontario Psychological Association is one of the signatories to the joint submission of the coalition of regulated health care professions. We have, however, prepared a separate submission in order to highlight and focus on the issues of greatest concern to the psychology profession. Dr Sinclair.

**Dr Carole Sinclair:** We're aware that you do not have an easy task in considering Bill 100. The debate concerning this bill has often been impassioned, as sexual abuse by professionals evokes powerful emotions. Most of us experience shock, anger and even fury at professionals who abuse their power in this way.

As members of a discipline that contains perpetrators of sexual abuse, many psychologists also experience shame, disbelief and great sadness. However, we believe it's important to balance these strong emotions with wisdom and common sense in order to develop legislation that will protect the public not only in the short run, but in the long run as well.

I'm going to speak briefly to three items in Bill 100 which we believe have been driven primarily by emotion and which we consider quite unwise in the development of the best possible legislation. Dr Jackson will speak briefly to four additional items.

The first of my items concerns the inclusion of the group of offences called sexual impropriety under the general label "sexual abuse." Although sexualized, non-touching behaviour and remarks in a professional relationship are offensive and seriously wrong, their inclusion under the label "sexual abuse" distorts the generally accepted use of the term "sexual abuse," and at the same time tends to minimize for both the public and professionals the horrendousness of those offences which are included under the label "sexual violation and sexual transgression" in the bill.

Our brief suggests that the more neutral term "sexual offence" be substituted for the term "sexual abuse" wherever it appears in the bill and also suggests that there be a clear differentiation between the three levels of offences as set out in our written submission on page 3.

The second of my items concerns the requirement that all levels of offence be reported to the appropriate college, regardless of the client's wishes. Although Bill 100 protects the client in so far as it does not require the name of the client to be revealed unless he or she gives permission, many of our members are concerned that clients who have experienced sexual abuse by professionals will be unwilling to seek treatment if they know that a report will ensue automatically, regardless of their wishes.

Some clients need time and counselling to sort out their feelings about the professional involved and to understand that such a report is important, both to protect others and for their own healing process. Some clients have told us that they feel revictimized if the process of reporting moves more quickly than they feel ready for.

Ideally, the first step is to encourage survivors themselves to make a complaint, and if a survivor is unable to make a complaint, the next choice would be for the



psychologist to make a report with their consent. In spite of our misgivings about this aspect of mandatory reporting, we accept the need to protect the public from the most serious offences and, as such, our brief supports mandatory reporting of the two most serious levels of sexual offence by professionals.

However, we do not support mandatory reporting of the level of offence called sexual impropriety. Instead, we believe that legislating a duty to intervene, as set out on page 5 of our brief and also in the brief submitted by the coalition of associations, is more appropriate, will be more effective and is more immediate in dealing with this level of offence. A duty to intervene is part of the current ethics code for our members and is included on page 15 of our brief. For sexual misconduct, we would welcome the added statutory authority given by the inclusion of a duty to intervene in Bill 100.

The third and last of my items relates to the lack of an exception to mandatory reporting for health care providers who treat professionals who engage in sexual abuse. Psychologists represent a significant proportion of health care providers who treat such professionals and who are competent to assess whether they pose a risk to society by repeating their misconduct. We know that it is the somewhat more responsible and remorseful and insightful professional who seeks treatment on their own. Yet by the lack of an exception to mandatory reporting for the health care providers who treat them, these very professionals will be discouraged from seeking treatment that is aimed at helping to reduce the likelihood of their reoffending or of their offences becoming more serious. A preventive early intervention tool will be lost.

We urge the government to amend the bill to exempt treating professionals from reporting except in circumstances in which the treating professional judges that there is a risk of continued or repeated abuse.

**Dr Iris Jackson:** I'm going to be speaking about non-party participation, or intervenor status.

The Ontario Psychological Association is sympathetic to any survivor's desire to be actively engaged in the complaints and discipline process. They have a right to tell their stories and to have impact on the process that ensues from their complaint of abuse.

We think that Bill 100, as initially proposed, fell short in that it did not guarantee survivors the opportunity to address the discipline committee panel after there is a finding of guilt, and we support the amendment to section 11(3) of the bill that has been tabled by the government. Impact statements will be beneficial to the survivors and will ensure that the panel has a complete understanding of the harm caused by the abuse.

However, we oppose non-party participation prior to a finding of guilt. It poses too great a risk of procedural injustice to members of the college, which translates into increased risk of successful appeals and judicial reviews. It may well be a hollow right as well because many survivors may be unable to afford legal representation at the hearings.

Furthermore, Bill 100 does not address an acute problem that arises at hearings when the complainant's

past psychological or psychiatric treatment records, where they exist, are introduced in evidence. It is understandable that survivors would demand the right to participate in the hearings to oppose the production of these records. We believe the potential for damage to survivors calls for rules that records cannot be produced except where the effect of non-production on the hearing would be more detrimental than the negative effect of production on the client. Page 7 of our written submission lays out the rules we recommend when considering whether such patient records should be introduced into the discipline hearing.

The program for funding counselling: Psychologists, more than most, are aware of the financial obstacles that prevent many people in Ontario from obtaining mental health services, particularly psychotherapy. For many years we have been trying to persuade the government to adopt funding and service models that would make psychological services more widely available, but we have many objections to the funding proposals in Bill 100.

Sexual abuse is a societal problem. Only a few of the survivors will ever benefit from funding. Therapy will be inaccessible to many survivors, including people abused by unregulated professionals.

Second, shifting the financial burden to the professions means that financial resources will continue to be in short supply. It is imperative to include provisions in the bill to ensure that these resources are used most effectively.

It is very important to insist that an assessment of a survivor is undertaken to determine the nature and goals of counselling. It is also important to determine that the therapist selected by the survivor is competent and has a treatment plan in mind. We also wish to point out that we are aware of no other funding program, including OHIP, where entitlement is absolute, regardless of therapeutic necessity.

#### 1720

Finally, while we agree that everyone should have the right to choose his or her own therapist, funding should only be provided to therapists with recognized credentials. It is irresponsible to spend scarce resources on therapies of no proven value and on practitioners who, because they are unregulated, are accountable to no one. For these reasons, we urge the government to restrict funding to regulated health professionals, and if this is not possible, then to develop a list of acceptable categories of therapists. These lists could be included in a schedule to regulations.

Bill 100 includes an amendment that will empower the discipline committee panels to order members of colleges who have been found guilty of professional misconduct or incompetence to pay the college's investigative hearing and legal costs. This amendment goes far beyond the authority in the actual award costs to a member who is acquitted. That member may only be awarded costs if the panel finds that the proceedings ought never to have been commenced. Apart from this imbalance, we are very concerned that the threat of a substantial cost order may have the effect of coercing innocent practitioners into pleading guilty. At the least, we oppose an unrestricted authority to award costs and we recommend that the



maximum amount of the order be fixed by regulation.

Finally, sexual offences are a form of psychological harm. Nothing in Bill 100 or the RHPA addresses psychological harm in the same manner that physical harm is addressed by section 30 of the RHPA. Sexual abuse statutes enacted by most USA jurisdictions cover abuse by all kinds of psychotherapists, not just regulated ones. It is impossible for us to understand why the government of Ontario is taking no action in this area. We recommend that a provision be added to Bill 100 to prohibit any person, regulated or unregulated, who is providing treatment or health advice to an individual from sexually abusing that individual in the course of providing such treatment or advice.

In conclusion, we would like to affirm the Ontario Psychological Association's commitment to zero tolerance. This afternoon we have touched on issues of great concern to psychologists. We hope that you will also study our written submission. We have tried to propose workable solutions to the flaws we see in the bill and we ask that you give them serious consideration.

**Mr Jim Wilson:** Thank you for your presentation. I agree with some of your concerns or at least flag them as concerns, particularly in the area of the treating professional having to report on the patient practitioner, as it were. You mention, and it's the third or fourth brief I've read, where that report to the college may be taken as tantamount to a confession by the named professional. That really does worry me.

Since I only get one question, how are we going to improve the bill so that there's some direction given to the colleges on how to handle these reports? I think the bill attempts to have a bit of a screening process, but none the less, a report by a professional is rather a serious matter.

**Dr Iris Jackson:** I think with regard to psychologists, one of the things that is important to recognize is that, as a diagnostic profession, we're in a position to assess whether the person we are seeing can be rehabilitated. I think it's reasonable to leave some level of discretion to the treating professional whether or not to report to the college. As you point out, there's a great deal of machinery in place, once the report goes in, that the college will have to take very seriously any report by a treating professional.

**Mr Jim Wilson:** Your suggestion was the exception that there not be mandatory reporting unless there is a belief that the abuse will continue or be immediate.

**Dr Iris Jackson:** That's right. If there's a chance that the professional in treatment is going to continue to abuse, then we have both the ethical and I think legal responsibility to report to the college.

**The Chair:** I'm sorry that we're out of time, but thank you very much for your submission and also for the written submission.

#### COALITION OF REGULATORY COLLEGES

**The Chair:** I would next then call the representatives from the Coalition of Regulatory Colleges. Could I just indicate to members that there is a vote being called. Although it is 27 minutes away, it's my intention to try

to go on as best we can, and again I remind those who are here we are going to do our very best to hear from everyone. We may have to go up for a vote or several votes and we will come back. Ms Haslam, you wish to make a short comment.

**Mrs Haslam:** No, as a point of clarification about the timing. The reason we're having such a difficulty is because we were scheduled to start at 3:30. Due to some delays in the House, we didn't start until 4 and you're trying to push them all in and I understand that. But looking at the schedule ahead, I just wanted to, as a point of clarification, say, are we going to have this problem over the next few days or is it just because the delays are here today?

**The Chair:** Hopefully, what happened in the House today won't happen tomorrow or next week. I can't speak to that, but we will certainly honour the time for everyone.

Welcome to the committee. Perhaps you would be good enough to introduce yourselves, and then please go ahead.

**Dr Catherine Yarrow:** Thank you. Good afternoon. My name is Catherine Yarrow. I am the acting registrar for the Ontario Board of Examiners in Psychology. With me today are Sharon Saberton from the Board of Radiological Technicians, Jane Rogers from the Transitional Council of Dental Hygienists and Janet Ecker from the College of Physicians and Surgeons of Ontario.

Our coalition represents 16 regulators of the health professions in Ontario. We are the ones who will have to implement Bill 100. We are the ones who receive the complaints and investigate reports of sexual abuse. We are the ones who discipline members of our professions in matters relating to sexual abuse.

The coalition of health regulatory colleges does support Bill 100 in principle. The coalition supports zero tolerance. However, our mandate in protecting the public requires that we ensure that we are able to do our jobs effectively in conducting discipline and professional regulation, and our concerns are that Bill 100 in its present form is not practical and workable and that there are some flaws which will prevent our effectively carrying out our mandate.

Today we have chosen to speak only to two issues in the bill, although you will see from our written submission we've addressed others. I'll ask Sharon Saberton to begin to speak about the definition of sexual abuse in the bill.

**Ms Sharon Saberton:** The definition of "sexual abuse" will be used in two ways: number one, to determine sexual abuse for discipline purposes, and to tell practitioners what they must report. Because a failure by a practitioner to report sexual abuse can result in a \$25,000 fine, the definition must be clear. Even responsible practitioners will be confused about what to report if the definition is imprecise. The results could be that, number one, no one will report anything and the perpetrators will continue to be free, or everyone will report everything and the perpetrator will still go free in a flood of paperwork.

The government has recognized this concern and has suggested that only behaviour or remarks that are demeaning, seductive or exploitive be reported on a mandatory basis. However, the words "demeaning," "seductive" and "exploitive" are subjective and may not provide enough guidance. Perhaps a better alternative to the ministry's proposal is set out in our submission and on the sheet on page 2 that we have handed out.

For the purposes of the definition of "sexual abuse," the phrase "sexual in nature" should not include touching, behaviour or remarks of a clinical nature appropriate to the services provided. This clarification provides an objective test that distinguishes clinical remarks in sexual component such as sexual-history-taking during the course of treatment from improper remarks that ought to be reported. This test is also one that most practitioners would understand and more readily report.

Now I'd like to turn it over to Jane Rogers to talk about our second major issue.

1730

**Ms Jane Rogers:** The fund is of major concern to the coalition. We agree that survivors may need therapy and counselling and that some may require assistance to obtain it. The coalition also agrees that it is the responsibility of each college to assist complainants to come forward and to proceed through the disciplinary process.

However, the coalition is fundamentally concerned about whether colleges can or should provide or administer a funding program. No matter how fairly and effectively the colleges administer the fund, the public will always see a conflict between the body determining guilt and that same body having to give money out based on the determination.

The mandate of the colleges is to regulate and discipline their members; it is not to provide moneys for health services to consumers who have been harmed. That is the role of the courts, insurance and the Ministry of Health.

The coalition has many additional specific concerns that are outlined in our submission. For example, the coalition is concerned that the financial burden of this fund will jeopardize the survival of many colleges, some of which can only sustain operating budgets of less than \$150,000.

Also, many unregulated therapists are not accountable to any public authority for their conduct. While we acknowledge the survivors' desire to choose their therapists, we are concerned that they will not adequately be protected.

The members of the coalition would like to thank you for taking this time to hear our submission. We purposely kept it short so that we would be able to answer some questions, and we'd be happy to take them at this time.

**The Chair:** Thank you very much. That may allow us a couple of questions. We'll begin with Ms Haeck, who has been patiently waiting.

**Ms Christel Haeck (St Catharines-Brock):** Yes, I have been patiently waiting. Actually, I have a great many questions. I'm one of the two members sitting on this committee who went through the joyful process of

RHPA, so I have many recollections of the range of comments you're making. Some of them have remained with me in an almost intact state, so I find interesting your comments around touch and harm. But I did want to raise the point of the sexual impropriety that you raise on page 2.

My major concern is that we have in our midst a range of people who may be perpetrators of a type of sexual impropriety which frequently could be seen in some sense as locker-room humour, which someone who is a vulnerable person would not be in the position to respond to. This is just sort of the normal course of action, and it does in fact perpetrate harm on that person's self-confidence and how they view themselves.

As you describe this as an abuse, it is, to my mind, minimized. I feel that the way the ministry has put it together at this point provides really a much more appropriate method. I would be interested in any further comments you have to make.

**Ms Saberton:** Certainly it is recognized that remarks can be just as painful and perhaps as damaging as the other types of sexual transgression. What we were trying to clarify was the issues around the difference between the appropriate clinical nature of remarks and behaviours so that it is clearer to define what is correct and what is incorrect.

**Dr Yarrow:** The focus was to be on what is appropriate clinical practice. There are times where one may have to deal with sexual issues. The intent was not to tolerate remarks that were inappropriate or not clinically required and which could be harmful; it was really to try to give clinicians a clear means of distinguishing whether one sexual remark or comment or behaviour was relevant to the practice and others are not. We didn't want to create a landslide of mandatory reports which may have been unnecessary. At the same time, it still allows for the recognition that there are certainly types of conduct of this sort that are unacceptable and inappropriate.

**Ms Janet Ecker:** It also makes prosecution a bit more difficult if you use words like "demeaning," "seductive," or "exploited," in terms of trying to prove that in a discipline context, where the wording we are putting forward we think will assist us in that regard.

**Ms Haeck:** I guess I'm concerned in that I consider myself a consumer of the health care system, although as a result of my schedule I may not be looking after myself as well as I should be on occasion. But if I am, say, visiting a gynaecologist, there is a range of concerns I would have in the kinds of clinical comments. As someone who has a master's degree, I am probably reasonably able to understand the difference between a clinical comment and one of a sexual nature—not to suggest that a vulnerable person in all instances would be. I think the basket that basically falls into in the current legislation is such that it's the persistence, not just the occasional remark. I've seen my gynaecologist for the last 20 years. The way we might discuss something might be different from someone you see the first time. We have to develop some sensitivity and sensibility, but I think we're all aware that there are those practitioners out there who use that as a regular course of practice.



**Ms Rogers:** What you have to remember with this mandatory reporting of remarks is the fact that it's mandatory. For instance, as a dental hygienist myself, if I happen to be walking by an operator and hear something and don't report it, someone else can say, "That hygienist heard that remark and she didn't report it." I am then subject to a \$25,000 fine.

What we're trying to say is that it has to be understandable for people to realize what they have to report. If it's a very vague thing, people will either report everything they hear or they'll start to close their ears and say, "No, I didn't hear it."

**The Chair:** We have time for one more question, and then we're going to have to break to go to the House.

**Mr Jim Wilson:** I agree that the final bill is quite a bit different from the CPSO task force recommendation with respect to funding of the survivors' fund or the therapy and counselling fund. The final bill means the government essentially gets rich off these fines, that it gets the \$35,000 fines, and your members bear the costs of the therapy and counselling for survivors. This whole discussion was sold to the public quite differently, so I'll give you an opportunity to comment on that.

The government tells us it is absolutely impossible, though I do recall in its opposition days it was quite possible, to designate funds like these fines to go back into the therapy and counselling fund. They're now telling us that's absolutely impossible, and I want you to comment on that.

**Dr Yarrow:** Our main concern was that we be realistic about what can and cannot be done. We're not denying that there's a need for individuals who have suffered abuse at the hands of providers to have supportive counselling and therapy, but there certainly is a concern that it's not realistic or practical to anticipate that the colleges can absorb the cost or that their membership can absorb the full costs, particularly if there is multiple abuse; as many of us know from experience, if you find a practitioner who has abused, it's not uncommon to find that there has been more than one client who's been the subject of abuse. Our concern is that we look for a means of funding the therapy which is fair and equitable and achievable as well. We're not convinced that the proposal in Bill 100 is the best way to accomplish that.

**The Chair:** At this point, I want to make sure I can allow the next three presenters their full time uninterrupted. For that reason, while there's approximately—

**Mrs O'Neill:** Then can I ask a supplementary on that one Mr Wilson just asked?

**The Chair:** You may ask a supplementary.

**Mrs O'Neill:** I'm quite interested in your alternatives to the fine. I want to ask too, will the individual doctors just have to increase their liability insurance? Could you say something about those kinds of things?

**Dr Yarrow:** The notion of an insurance scheme was one possible alternative. As you know, the goal of that proposal was to put the funding and its administration at arm's length from the college, to obviate the clear public perception of a conflict of interest, where we'd be on the one hand making a finding of discipline which is going

to cost us money a few moments later. That was the proposal for that. It would, if it were conducted in that way, necessitate an increase in liability insurance. There are some carriers willing to look at providing that, and naturally they will just charge us whatever it costs to provide that.

The other things we're recommending, of course, were broader-scope issues which other individuals have spoken to earlier today; that is, to look at the broader problem of sexual abuse and the need for funding for therapy for victims of sexual abuse in relationships of trust on a broader scale. That would involve creation of support groups, and regulated professionals, among others, having fines and levies contributing to the funding for those types of programs, or to identify specific counsellors who would be well trained to deal with the victims of sexual abuse, again across the board and not just specifically for clients of regulated health professionals who've been abused.

**Mrs O'Neill:** Much more all-embracing. Thanks.

**The Chair:** Thank you. May I just say, before we adjourn, the Ontario College of Audiologists and Speech-Language Pathologists, the Ontario Chiropractic Association and the Board of Directors of Chiropractic, we are approximately 10 minutes from the vote. We will return here as soon thereafter as we can. We will do our very best to make sure everyone is heard. This committee stands adjourned until the call of the Chair.

*The committee recessed from 1742 to 1757.*

#### TRANSITIONAL COUNCIL FOR THE COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF ONTARIO

**The Chair:** Good afternoon; it being before 6, I will continue to talk about the afternoon. Our next witnesses are the representatives from the College of Audiologists and Speech-Language Pathologists of Ontario, if you would be good enough to come forward. Thank you very much for waiting for us. We have a copy of your submission. If you'd be good enough to introduce yourself, then please go ahead.

**Ms Barbara Meissner Fishbein:** My name is Barbara Meissner Fishbein. I'm a speech-language pathologist. With me is Isobel Manzer, who is the registrar of our soon-to-be-regulated college, and before that she was an audiologist.

We'd like to say at the outset that we have strong support for the intent of Bill 100 and strongly agree with the philosophy of zero tolerance for sexual abuse. The other thing we'd like to point out is that we did participate in the submission you heard from the Coalition of Colleges and Transitional Councils and have adopted those positions as our own. What we'd like to do this afternoon is outline a few of the areas that are of particular importance to us.

Regarding the definition of "sexual abuse," what we'd like to do is just reiterate the coalition's position. We would suggest leaving the definition as it is currently written in Bill 100, with the addition of a subsection which defines "sexual nature" as not including "touching, behaviour or remarks of a clinical nature appropriate to



the service provided." We refer you to the coalition rationale and would adopt that as our own.

We'd like to turn now to the issue of mandatory reporting. We support the ministry proposal to remove cross-professional mandatory reporting of incompetence, incapacity and misconduct. We also support mandatory reporting of physical sexual relations and touching, as is outlined in Bill 100.

We would also like to say that we can support mandatory reporting of remarks and gestures if the definition that we discussed is adopted.

As well, it is our belief that mandatory reporting to an alleged offending member's college is but one option. In situations where an alternative dispute resolution mechanism exists, referral to this process may quickly and effectively deal with the offence.

If the alleged offender has previously been referred to an alternative dispute resolution process, then a report to the college would be mandatory.

As well, if one of these mechanisms was not available to one of our members, again they would be obligated to report to the alleged offending member's college. We do not feel our membership should be fined for failing to make a report to a college when the issue was raised through an ADR mechanism and dealt with quickly and appropriately.

We'd now like to discuss the issue of non-party participation. We have had the opportunity, through the consultation process undertaken by the ministry, to hear from both existing colleges and survivors.

We concur with the arguments which state that discipline hearings will become unmanageable with any further extension of non-party participation. We're concerned that granting party status to survivors would not increase the number of successful convictions.

In fact, our fear is that the opposite may occur. The added complexity to the process may lead to errors in law which could be used to overturn findings even though a member may be factually guilty. This would add a significant demand to our already limited resources, being a newly regulated college.

In addition, we also feel the arguments put forward by the survivors for party status deserve serious consideration.

CASLPO would suggest that the section regarding non-party participation, 41.1, stand as written, with the addition of a subsection which would exclude evidence which is called, if a survivor has no status, if the sole purpose of that evidence is to discredit the survivor. If the exclusion of such evidence should hamper a member's defence, the survivor should be granted intervenor status under section 41.1.

The survivor as well, in any case, should be allowed to attend the entire hearing and provide a written impact statement at the penalty stage.

In addition, and most importantly, we feel that the survivor needs to be provided with support from the time a complaint is made until the disciplinary hearing has reached its conclusion. This would provide the survivor

with knowledge of their rights and options throughout the process and could include access to independent legal counsel.

Such an advocacy service could come from an independent agency, and we'll discuss that agency more when we talk about funding. This could be specifically set up to assist survivors of sexual abuse. The service could also provide the counselling required. Again, we'll discuss that.

I'd like to turn now to the issue of funding. We would like you to recognize that there are problems with the funding section the way it is currently written. You've heard about the problems regarding having unregulated therapists provide therapy for survivors. There would also be an undue financial burden placed on small and newly regulated colleges such as ours.

What we would like to propose is the creation of an independently run service agency which would be devoted, among other things, to the provision of advocacy, as we discussed before, legal advice and counselling to victims of sexual abuse by regulated health care professionals. Such an agency could become a centre of excellence in the area of supporting and treating survivors of sexual abuse.

It could encompass a number of functions, including education and advocacy that survivors require in the initial stages of making a complaint and throughout the hearing process. The type of therapy provided could be varied to meet the individual needs of survivors.

If a survivor chose to receive therapy from an independent, unregulated therapist, criteria could be established and adherence to the criteria monitored to ensure that the therapist had the required skills.

It could allow for the development of survivors' support groups, which have been shown to be an effective method of assisting survivors. It might also oversee professional education and research in the area of treatment of survivors of sexual abuse.

The sources of funding for this agency could include dedicated funds from all of the colleges, fines imposed on guilty practitioners and recovery of OHIP and other fees billed by sexual abusers, as well as funding from government, granting agencies and private and corporate donations. Colleges might be assessed on the basis of their total annual budget to ensure that no college faces significant hardship in supporting therapy for survivors of sexual abuse. This would give the colleges financial responsibility without the administrative responsibility, thus ensuring fair and impartial provision of therapy.

The independently run service agency approach would allow for a free choice of therapist, with a monitoring mechanism to ensure that the proper services are being provided. It would address many of the concerns that survivors have expressed regarding non-party status. Most importantly, it could assume a leadership role in working towards the prevention of sexual abuse, and it would provide a strong expression for the concept of zero tolerance of sexual abuse.

We'd like to thank you for listening to our submission this evening and welcome any questions.

**The Chair:** We have time for a question.

**Mr Jim Wilson:** There's one line on page 5 at the bottom of your written submission that's somewhat disturbing. It says:

"It would be in CASLPO's financial interest to limit our investigations to find as few victims as possible, thereby potentially leaving many other survivors without resources for counselling. Under this scheme, colleges will be undermotivated to pursue convictions of members for sexual abuse."

Earlier in that paragraph you talk about that at the time of proclamation, you're likely only to have just over \$10,000 in the survivors' fund.

**Ms Meissner Fishbein:** That's what we're required to have, which is the cost of funding one survivor.

**Mr Jim Wilson:** None the less, if the funding section isn't changed, you stick by the statement that the colleges might find themselves undermotivated?

**Ms Meissner Fishbein:** I think the issue is that an abuser may have more than one survivor. If we are obligated to provide the funding for every survivor who comes forward, it may not be in our interests to look very hard for other survivors.

**Mr Jim Wilson:** I'm not sure how much help we're going to be able to be in terms of introducing amendments, given that we were just up in the House and some of the opposition members look like we have long faces. We had presented to us a time allocation motion, which means this committee will be very limited in what it can do, and debate in the House is to be limited to something like two hours on this particular bill. So there's a little bit of news for you.

**The Chair:** Thank you very much for coming before the committee today.

#### ONTARIO CHIROPRACTIC ASSOCIATION

**The Chair:** I'd like to call on the representatives from the Ontario Chiropractic Association, if they would be good enough to come forward, and following them the last presenter today will be the Board of Directors of Chiropractic. Once you're settled, please introduce yourselves for members of the committee and for Hansard and then please go ahead.

**Dr Janice Hughes:** Good evening. My name is Janice Hughes and I'm here representing the Ontario Chiropractic Association. On my left I have Dr Deborah Kopansky-Giles, who is also a director, and on my right I have David Chapman-Smith, who is our legal counsel.

The Ontario Chiropractic Association is a voluntary professional association that represents over 80% of Ontario's 1,750 chiropractors. The chiropractic profession, like massage therapy, is a hands-on profession.

We have followed the development of Bill 100 closely and we have been an active participant in the ministry's consultation process. We support all the fundamental goals of the proposed legislation. However, we feel that the pendulum has swung too far, that various aspects of Bill 100 are ill-advised and unfair to health professionals and that a number of amendments are required to make the legislation successful in achieving its stated goals.

The OCA is a member of the Ad Hoc Coalition of Regulated Healthcare Associations and has participated in all its deliberations, including a series of joint meetings with representatives of survivor groups, health care associations and colleges and the Ministry of Health. The OCA endorses all of the recommendations in the coalition's submission to this standing committee, including recommendations on the definition of "sexual abuse," mandatory reporting by professionals, intervenor status, the therapy and counselling fund and the grafting of Bill 100 onto the Regulated Health Professions Act.

#### 1810

In the limited time available today, we wish to highlight two issues of particular concern to our members:

Our first issue, the source of funding for therapy and counselling fund: Bill 100 proposes a levy on health providers. The suggestion that compensation for injury or loss caused by one health professional's illegal acts should be the responsibility of that professional's colleagues and part of the burden of self-regulation is wrong. It is not only wrong in principle but also manifestly unjust.

Our recommendation is that we support the coalition's recommendation that there should be a consolidated fund funded through general revenues.

We also recommend that all fines and orders for costs imposed on health professionals found guilty of sexual offences with respect to patients be paid into the fund.

Our second issue today is the definition of "sexual abuse." The present definition is inappropriate for the various reasons explained in the coalition's submission. There should be three categories of offence as originally proposed by the government.

Two major areas of concern are to ensure that the new system of reporting actually works in practice, and the unfairness to health professionals of having all allegations of sexual misconduct open to the public report as sexual abuse. In this submission, the OCA will seek to illustrate the latter of these points.

Our recommendation is that the OCA agrees with the coalition's recommendations.

In the area of the therapy and counselling fund, the therapy and counselling fund proposed is in fact a compensation fund. This is what it was first called by the ministry, and victims and survivors have consistently pressed for other categories of compensation from the fund. The OCA summarizes its positions as follows:

(a) A patient relations program, aimed at prevention of sexual offences in the professional setting, is clearly a valid part of self-regulation. A profession should bear that responsibility and cost.

(b) So is the bringing of disciplinary proceedings to determine whether or not a member of the profession has been guilty of misconduct.

(c) Compensation of a complainant, in the present case a victim or survivor of sexual abuse, is not a valid extension of self-regulation.

The inappropriateness in principle of asking members of a profession to fund compensation for victims or



survivors of a sexual offence may be illustrated in various ways, including the following:

Example 1: Consider a different area of practice. Assume a case in which a chiropractor is guilty of professional misconduct in suggesting wrongly to a 10-year-old boy with scoliosis, which is spinal curvature, that he will be confined to a wheelchair by the age of 15 unless he has a prolonged course of chiropractic care. As a result of duress, the boy and his parents spend over \$2,000 on unnecessary treatment before they break away and complain to the College of Chiropractors of Ontario. In this case, injury and loss includes the following: psychological damage to the boy and perhaps the parents, as well as the cost of treatment.

Who should provide compensation? Another chiropractor elsewhere in the province of Ontario, the college of chiropractors or the offending chiropractor who has been guilty of misconduct and is liable in negligence?

Clearly, it is inappropriate to shift any responsibility for compensation to others in the profession. The same is true in all areas of misconduct, including sexual misconduct.

The pendulum has swung too far. Fundamental principles of fairness have been ignored when practitioner A must compensate the patient for practitioner B. Again I state that the pendulum has swung too far.

Example 2: Power and intimacy are found in many other relationships in society: in religious, charitable, voluntary, educational and sporting settings. A lawyer practising family law or personal injury law is often placed in a similar relationship with clients and minors. In none of these circumstances do other professionals, other workers or their organizations carry the responsibility for compensation for victims or survivors of sexual offences. It is wrong to create an exception for regulated health professionals.

Example 3: During consultation on Bill 100, ministry representatives have suggested that the proposed compensation fund for victims or survivors is analogous to and can be justified by the lawyers' fund for client compensation established under the Law Society Act. That reveals a complete misunderstanding of the law society fund and is invalid.

Firstly, that compensation fund was established on the initiative of the legal profession. This was to create increased confidence in and use of legal services by providing guarantees against dishonesty and fraud. It was not deemed by government that lawyers had a social or professional duty to compensate victims.

Secondly, that compensation fund is based upon a distinct and separate legal relationship: a fiduciary relationship in which a lawyer acts as a trustee for the client with respect to moneys placed under the lawyer's control.

The OCA adopts this statement by the coalition concerning the important but limited collective responsibility of a profession as a whole for the conduct of its individual practitioners:

"That collective professional responsibility includes setting, monitoring and enforcing standards of practice

through financially supporting the regulatory function. It does not extend to covering the cost of treatment of patients mistreated in some way by practitioners. The therapy and counselling fund contemplated by bill 100 takes collective professional responsibility into new and uncharted territory by imposing a levy on the vast majority of health care practitioners to fund counselling and therapy resulting from the aberrant behaviour of a few."

The next issue is a definition of "sexual abuse." Here again, the OCA adopts the reasoning and recommendations of the coalition. Under Bill 100, as drafted, any comment or any behaviour interpreted by a patient as being of a sexual nature may give rise to a complaint. The offence complained of is called "sexual abuse." To illustrate what this means for health professionals, and the potential for devastating and unfair consequences, see the attached item from the *Globe and Mail* published last Friday, November 12, 1993.

This is further publicity concerning sexual misconduct complaints against a Toronto physician. As yet, there has been no hearing of a complaint or finding against him and he must be presumed to be innocent. If he is subsequently found guilty, most people will not view this publicity as unfair, but on the other hand, if his innocence is confirmed, most will feel this pre-trial publicity was most unjust.

Next to the *Globe* report is a rewritten headline and article changing "sexual misconduct" to "sexual abuse." Imagine that this relates to a complaint that relates to comments only that is subsequently dismissed as unfounded. An appropriate balance of interests requires that there be three levels of sexual offence as outlined in the coalition's submission.

Next to that, and the final headline, relates to an MPP. Imagine that this is you. The basis of the complaint is an alleged comment with no touching whatsoever. The complaint is unfounded; it is a misinterpretation of what you have said. Your legal advice is that you should not make any comment or explanation to the media pending possible charges and a hearing.

In conclusion, the purpose of this submission has been to highlight two points of particular concern to the OCA and its members. There has been insufficient time to provide more complete commentary. The OCA adopts in full the submission of the Coalition of Regulated Health Care Associations.

However, in conclusion, the OCA wishes to acknowledge that it endorses all the fundamental principles found in the Report of the CPSO Task Force on Sexual Abuse of Patients and Bill 100: in particular, the principle of zero tolerance, the related principle that no sexual offence is trivial, and the principle that there should be stringent reporting requirements on health providers, their employees and others.

Strong and effective new measures are necessary to prevent sexual offences and assist victims and survivors. However, the legislation must have a proper balance of interests if it is to gain acceptance and achieve its desired goals.



Thank you for giving us this opportunity tonight.

**Ms Haeck:** I would like to briefly comment on your ads, and as far as being an MPP who has frequently been misquoted is concerned, there is absolutely no possibility for righting the wrong. We have to accept that in a way others do not. Other people get a chance to deal with libel and other groups and that's not possible if you're an MPP.

1820

The interesting thing I would like to ask as well is, why should general revenues per se basically be used to compensate, as you say at the bottom of the page in the introduction and executive summary? You have (a) and then recommendation (i).

**Dr Hughes:** I'll address that. Actually the basic premise behind it is that it's unjust that I pay for someone else's wrong. It's not unjust that there be compensation, but it's unjust that I then bear the burden or the responsibility for that person and his or her wrongdoing.

**Ms Haeck:** Why should the general public pay?

**Dr Hughes:** I think the basic premise is that there has to be a different mechanism of coming up with a compensation fund, that general revenue represents the population as a whole and that's where the victims are coming from, whereas again, by us or a member bearing the burden, that's unjust.

**Ms Haeck:** The college is there to protect the consumer, and if in fact the college cannot provide the mechanism for consumer protection, at least to even provide some counselling that might see that person rehabilitated at an earlier date, would that not be seen as sort of a proper action to counteract what the professional has undertaken?

**Mr David Chapman-Smith:** With the greatest respect, I would suggest that while the college has a clear role to protect the consumer as far as it can, it obviously doesn't have a total, black-and-white duty to protect the consumer in every respect. The point that we've tried to make clearly in the submission today is that there is a huge leap from working on prevention and from bringing to discipline members who have done wrong or may have done wrong to actually compensating victims. They need compensation, but why should it be from Dr Hughes?

If I might very briefly put it in this perspective, because it would be wrong for any of the chiropractors here to say it, but as their attorney perhaps I can, look at Dr Hughes here. She has a master of science and then has spent four years at chiropractic college; came out a few years ago with a huge debt; has entered a profession where 30% of its members earn \$30,000 net or less per year, where there is tremendous restraint on their earnings, their incomes are frozen; she already pays over \$3,000 a year for membership associations, college membership and malpractice, and she is now asked to start paying compensation for patients who need compensation. But why from her?

**Ms Haeck:** One of my concerns is that having sat through the RHPA process and listened to a range of professionals who wanted to have college status, one of the major concerns why certain groups were not granted

college status was because of the size of the group practising that profession. The catchment area or the catchment base in the case of the colleges that were looked at during the whole Schwartz process and ultimately RHPA were all deemed to be in a position to financially afford becoming a college, and dealing with the regulation and being able to pay for the per diems of the sitting members who were going to be coming on board.

It was well understood through the RHPA process that this particular legislation would be part and parcel of the act. That came through the whole clause-by-clause. That was right there. There were placeholders indicated at the time. We went through clause-by-clause and indicated that the area of sexual abuse would be addressed within the RHPA for each college. So basically, to my mind, there was a flag raised that consumer protection, especially in this area, was going to be something the colleges would have to deal with.

**Mr Chapman-Smith:** Because there is such an evident and huge need in this area, there has been an effort made in the submission to give an example from a completely different area of practice. I can tell you that the example taken, sadly, incorporates some material facts from one of the worst cases there has been before the chiropractic disciplinary board over the last 10 years.

But should Janice pay for that little boy's counselling too and compensate the family for all the payments? There is a clear need for the victims, but the case put forward by the OCA is that it's no part of self-regulation to be compensating for loss. That's as clearly as I could say it.

**The Chair:** I think the issue is joined and your point is clear. Thank you very much for coming before the committee.

#### BOARD OF DIRECTORS OF CHIROPRACTIC

**The Chair:** I would then call on the Board of Directors of Chiropractic to come forward. Welcome to the committee. We apologize for the lateness of the hour, but please introduce yourselves and proceed with your submission.

**Dr Edward R. Burge:** We thank you for the opportunity. I certainly realize that you've had a long day and I'll try to get to the point. I think probably my submission is going to take a little bit of a different direction than some of the others may have.

My name is Ted Burge and I'm the chair of the Board of Directors of Chiropractic. On my right is Jo-Ann Willson, who is a lawyer and our director of policy analysis and research with the board. Dr Stan Stolarski is the registrar.

Just for your information, I've been involved in this regulatory process for eight years, going back into the early days of Alan Schwartz and on through, and I have personally chaired 80 formal hearings, which has given me a perspective in looking at Bill 100 as it relates to the RHPA from maybe a little different perspective.

We've had, as a board, many opportunities to strengthen the regulatory process with our input and to be part of a team that's helping to do that, but one of the

concerns we have at this point in time is that our experience leads us to believe that some of the proposals in Bill 100 are seriously flawed. We've got serious reservations not only about that but about the impact of Bill 100 on RHPA, because they are basically inseparable, being that one act is there to amend another.

I'm just going to compare for a second, and I'll try to be brief—

**The Chair:** Dr Burge, sorry, could I just ask you, because people are watching this and they may just wonder what the difference is between the Ontario Chiropractic Association and the Board of Directors of Chiropractic.

**Dr Burge:** I thank you very much. As a matter of fact, I had overlooked making that distinction.

The Ontario Chiropractic Association is a professional association that is a voluntary membership of the practitioners in this province and carries out a mandate of dealing with the interests of the practitioner. The Board of Directors of Chiropractic is the regulatory board, the college, if you wish, and we deal with the disciplinary aspects of the college, with registration, examination and other issues such as that, including the complaints process. I thank you for bringing that to my attention.

**Ms Jo-Ann P. Willson:** The mandate is different in that the mandate of the college is to regulate the profession in the public interest.

**Dr Burge:** I'd just like for a moment to compare the nature of the process we had when we were dealing with the Health Professions Legislation Review with what we've had with Bill 100, and there's quite a difference.

I recall sitting here before this standing committee on social development a little over two years ago, I believe, at which point, and up until which point, there had been a very open consultative process, as established by the Health Professions Legislation Review, bringing us through to the provisions and the proposals that came into the Regulated Health Professions Act. This consultation process worked well and it was fundamental to the success of where RHPA came in 1991, at the time it received royal assent.

Alan Schwartz achieved many things, and one of the things he achieved was consensus. That's one of the things I want to point out to you today that I don't think has been achieved in Bill 100 to this point in time. Not only did he achieve a consensus, but he struck a balance. In fact, that was the title, if you will recall, of his report to the Minister of Health: *Striking a New Balance*. A balance sits between what one has to do to protect the interests of the public and proposals that are workable.

It's the workability that I've heard brought out today and proposals that are going to protect the public that are the two interests. I think Alan Schwartz, in his report, because of the type of process he had, was able to establish that balance, and that's one of the things I want to address today.

Most of the participants, after that process was over, were quite pleased with the proposals. The three parties endorsed it. There were no outcries of shortcomings. There was consensus, and in fact there was a balance. By

way of contrast, what has transpired over the last two years, I must inform you, has been rather disheartening in that it has been relatively devoid of open consultation; it's been devoid of consensus.

In fact, I've thought as I've been sitting here today, and what you may find is that the consensus you're going to hear is that everybody agrees that sexual abuse of patients by health care providers should be eradicated—everybody agrees with that—but I also think everybody agrees that there are a lot of provisions in Bill 100 that are seriously flawed.

We've heard from the Coalition of Regulatory Colleges today and also you've heard from the coalition of the associations. To my knowledge, this is the first time in the history of Ontario that there's ever been a need for a coalition. I think part of that coalition requirement has come out of the frustration of colleges in trying to get their voices heard, in trying to get into a process whereby they can make their experience meaningful to producing solutions to the problems at hand.

#### 1830

There's no objection to the principle of zero tolerance. I have not heard that in any quarters I've been involved in; there's no one who's condoning abuse. But the process that's been used to develop these proposals obviously hasn't worked, because there hasn't been any consensus.

We're all sincere in our desire to address sexual abuse, and the few days this committee has, as I've already heard comments today, are not going to be sufficient to address the seriousness of the concerns we have. In the instance that I sit here, I have 10 minutes to give you the concerns of my board and you've got 10 minutes to hear them. The concern our board has is that this may be the only opportunity in this decade, if Bill 100 goes through, that we really have to address this serious problem. The concern goes further to say that if the process is faulty and we're just pushing this process through to try to address an issue and not addressing it properly, then we're not going to solve the problems and we're not going to deal with the real problem, which is prevention of sexual abuse and establishing what zero tolerance really, really is.

So I have a bit of a challenge for you today, and the challenge is to understand that we can't separate Bill 100 from the Regulated Health Professions Act, because one affects inextricably the other. My challenge to you is that you've got to take a look at the provisions you've got and you've got to ask yourself whether they're really going to make the Regulated Health Professions Act better. I think that's the bottom line to what I'm saying.

We have to recognize, if we go back to the review and the report of Alan Schwartz, that many of the issues that are being dealt with now and recommendations that are being made now are quite contrary to the positions that were taken by Alan Schwartz based on a consensus. To give you some examples of that, the definition of "misconduct," where Bill 100 is going right now is where he was. Mandatory reporting: He took a position on that one that is quite different from what's happening here right now, as is the case with the issuing of fines.



Beyond that, there are some incorrect assumptions that are affiliated with Bill 100, and the most important one I think I can outline to you would be this: The assumption is that it is possible for the same body to adjudicate professional misconduct, impose penalties, award compensation to survivors of sexual abuse, satisfy members of the professions and complainants that hearings are impartial, and in addition to all this, finance and administer a compensation fund. Survivors, in the view of the board, are likely to believe that discipline committees will exonerate members to avoid making payments. Members may allege that complainants are motivated to complain in order to obtain access to the fund. Members are likely to believe that discipline committees impose large fines in order to finance compensation funds.

I've provided a list. In the back of the brief, there are two appendices, one outlining the concerns with respect to Bill 100, and another about some of these assumptions that you can peruse at your pleasure.

In conclusion, my point to you is that you're going to hear a lot of details about what's wrong with the bill from other presenters, and I think it's flawed because there hasn't been consensus. If it is flawed, it's not going to advance the interests of the public, and if it doesn't work, the problem of sexual abuse isn't going to be properly addressed.

I'm leaving you with a challenge that I think you're mandated to consider, and that is to understand that the Regulated Health Professions Act is built on a model of self-regulation, that professionals have a responsibility to regulate themselves, not necessarily be told every detail about how they have to do that, and I think the professions are prepared to take on that responsibility. If Bill 100 is to achieve the objective of advancing the public interest, you must decide if the proposals of Bill 100 are really going to meet that end.

I'm going to make a plea to you right now that you reconsider the proposals of Bill 100 on the basis that there's no consensus to support them, and I'm going to request that this committee recommend to the Minister of Health to establish a process that allows for a real consultation with all interested stakeholders. The process established by the health professions legislation worked well and we learned a lot from it, and it's my view that it's a much better way to reach consensus on how to deal with issues of sexual abuse.

The damage that's caused by sexual abuse demands nothing more than the most we can do to create the most effective legislation possible. We're not here to suggest that the thrust and the direction that we're going to use to deal with it is wrong, but that the way we're going about it is more than likely to encumber the regulatory system, which has been founded on a consensus and balance, with provisions that may not solve all the problems.

**Mrs O'Neill:** You've capsulized it perfectly. This is one of the major weaknesses, that the Regulated Health Professions Act took seven years in its making, and I think that's why it has been so well accepted. What we have here is a real, you'd almost say, snow job, certainly a bulldozer job to get this bill through. I feel it's an insult to the professionals, an insult we've had to listen to this

afternoon, to have professionals sitting in this room this afternoon who likely have a thousand years' cumulative experience not being given the opportunity to either be questioned by us or to be able to present their case to us as fully as they'd like, and each of you presenting executive summaries and trying to fit it into 10 minutes.

I have no questions. I think you have stated the real frustration we're all feeling. We know the bill is flawed, we know there could be amendments, and we're now being told we're going to have two hours in which to present any amendments that may come out of these hearings. Is this a sham? I don't know.

**Ms Willson:** Thank you very much for your comments. Sitting here and listening this afternoon, the theme I have got is that there has been insufficient time to properly consider this bill. Members of the committee, or at least some of them, appear to be frustrated because they don't have time to ask their questions. The colleges and the associations are frustrated; they haven't had time to attempt to reach a reasonable consensus with survivors. The survivors, some of them, appear to be frustrated; they don't feel their concerns have been heard.

This is such an important issue that I don't understand why the entire legislation is being pushed through. We have to remember that what we're dealing with is an amendment to a bill that has not yet been proclaimed. It's going to be proclaimed at the end of next month. Because the issue is so important, I don't know why we can't stand back and try and deal with it properly, allow all the stakeholders a real opportunity to try to reach a consensus and try and make something that's going to be workable as opposed to not workable.

**Mr Jim Wilson:** Thank you for your presentation. I agree with almost everything you said, Ted.

**Dr Burge:** Thank you.

**Mr Jim Wilson:** I guess that is the question: Why the rush? I'll tell you what's happening here. We've just been time-allocated, certainly contrary to anything the NDP ever campaigned on: They were going to be an open government; they were going to take the time to do things right. They accused my party and the Liberal Party of always rushing things through on some sort of corporate agenda or something like that. We've got time allocation in this House on a daily basis now, not to mention that last year they changed the rules on debate. None the less, their days in office are numbered and they want to rush this through.

I heard it on the steps on the way up and I heard it in the House and I heard it from some members opposite: When the colleges now plead, "Please get the bill right or it'll be unworkable," in fact at the end of the day this may backfire on survivors.

Ted, in a nutshell, you did a good job of talking about the almost transparent conflict of interest from the beginning of this thing to the end. The person who is alleged to have committed a sexual abuse will be dealt with totally by his or her own college. They will levy the fines, they will do everything. We just heard from the previous presenters that the way this bill is presented, because it's flawed, if it's passed as currently written we



may in fact find the whole thing backfiring; that is, that colleges say, "Look, we don't even want to deal with the issue of sexual abuse until we're absolutely forced to, and complain away, but we'll drag our feet on this." I don't expect colleges to do that, because they're professional people, but you may be forced to do that if you can't live with the bill or if it isn't workable.

I say to members, we're the ones who have to deal with the survivors. They're our constituents. If at the end of the day we pass legislation that's unworkable—and Ted's absolutely right. You know that with all the other things that have to be done by whoever forms the next government, it'll be at least a decade before we get back to this issue and it'll be at least a decade before we're in any way significantly opening up the RHPA. I agree that we took such painstaking time with hundreds of meetings and thousands of hours devoted to the RHPA process—long before I was elected; it preceded me by some five years—that I think we did come up with workable legislation.

**1840**

I really just echo what you've said. I want to give you a chance to respond to the accusation that was just levied at opposition parties and the colleges, that the reason you want to see this bill stalled for a bit is that somehow your hearts aren't in it and you're not there for the interests of survivors. I'll tell you, as an MPP, I resent that accusation totally because I know the survivors are ultimately my constituents and I'm responsible to them. Some of them may be my very best friends and my own family, and I think it's in all of our interests to get this right. I want you to respond to that accusation. I can tell you, it's the spin that's been going on for the last two hours and I'm just fuming about it.

**Dr Burge:** There were two elements. I'm going to address one and I'm going to ask Jo-Ann to address the other one. First of all, the Regulated Health Professions Act was no small piece of work, and there's every provision, in my view, within that act for our college to deal with any issue that comes before it with respect to any allegation of misconduct, be it defined as sexual or any other form of conduct.

I can tell you, the authority on which I can say that is that the Drugless Practitioners Act has one word, and it's "misconduct." It's not broken down into sexual misconduct and it's not broken down into abuse and it's not broken down into anything else; it just says "misconduct." If the Regulated Health Professions Act gives us the tools that are so far superior to what we have now, and if we're able to do it now—at least a lot of what has to be done now—with the poor tools we have, then the rush to get into this next step of dealing with specifics of one element of misconduct of health professionals is an issue that I find difficult to understand. In other words, we can, right now, address any allegation of impropriety, we can address abuse, we can address anything that comes before our college through a disciplinary process, so I fail to see why we're rushing through all of these other issues in terms of the specific words that we're trying to get consensus on and we're having trouble with.

The other issue I believe you wanted addressed was—

**Mr Jim Wilson:** About your stalling.

**Ms Willson:** I don't think that's a fair comment. I do think there's a sincere interest on the part of survivors and on the part of colleges and on the part of associations to try to resolve the problem. I don't think people are attempting to stall. The point is that unless all of the stakeholders buy into the legislation, it's not going to work for anybody. At this point, the stakeholders don't buy into it.

**Ms Haeck:** Again, I did sit through RHPA. I must admit I've forgotten how many verbal presentations there were, but I know we had at least 500 written presentations. I'm convinced that consensus was not achieved on a number of issues throughout a range of colleges. The number of breakfasts I had with David Chapman-Smith and Lloyd Taylor on the issue of how chiropractors felt and their concern about how the OMA felt I think was a pretty good example that there was no consensus on certain issues the association had—not your college, because the college wasn't involved, but the association; I do understand the difference between the two.

I understand there is a concern here with regard to a number of issues. But in light of the fact that the McPhedran report came down in the fall of 1991, we are now talking the fall of 1993, and since then the various issues around this particular bill have been discussed, including the fact that this bill would have been in committee probably during the summer; and as a result of the Liberal request from Mrs O'Neill or Mrs Sullivan, this was then taken through what normally would have been our intersession, where there was additional consultation through the professional organizations, as well as with stakeholder groups, in an attempt to achieve consensus.

My point, more a comment than a question, is that I don't believe that the survivors of sexual abuse can wait another 10 years, as the RHPA process dragged—I shouldn't say "dragged." It took a long time. Basically, at this point I think a decision has to be made. I personally feel that on behalf of a lot of the survivors out there who have been waiting for this to be resolved for some considerable length of time, the time has come. A lot of these provisions have been before not only the stakeholders but the survivors, the general public, for a fair bit of time. While there may be minor changes from various groups that come before us that I think are an advantage for us to bring forward as amendments, the substance that is brought forward here in Bill 100 I personally don't have a problem with, and I will be substantially voting in favour of it.

**Dr Burge:** I just want to make the point that I am a chiropractor, but I'm not here today because I'm a chiropractor. I'm here because I have a responsibility to protect the public interest. I've had an experience in dealing with disciplinary matters and I can see, as can all the other colleges—that's the message they're trying to give you—that there are some loopholes, there are some problems in this thing that aren't going to make the job easier; they're going to make it more difficult. That's the point I want to make.

I'm not here to defend or to speak against the issue of

implementing measures to nail this thing down as tight as it can be done. But if you don't have consensus and if you don't have people believing it can be done and if it isn't going to work, then the question is, why are we going to proceed at this pace? That is the only point I want to make.

**Ms Haeck:** The reality is that unless we actually start to give it a try, we'll never know. Waiting another however many years until we have that perfect solution, which I don't know—

**Mr Jim Wilson:** We're talking about days.

**Ms Haeck:** No, Jim, I think you have to be fair. This has gone on for two years. I think we are reasonably intelligent laypersons.

**The Chair:** Order, please. We have witnesses before us. Ms Haeck, if there's a question there—

**Ms Haeck:** Ultimately, it does come into our hands as laypersons who have to make the final decision in representing the public. The public, the survivors have spoken, that they want to see some changes in the legislation.

**Dr Burge:** I agree that there may need to be some

changes. I might just make one other point, if I may, Mr Beer. The objects of the college, as they were agreed to by consensus through a long process of consultation with the Health Professions Legislation Review, did not include the funding issue. I want to make that point because that is the major concern with respect to the regulatory colleges.

I understand that professionals and associations may have different views from ours, but this is a very conflicting position to place colleges in. It's not an issue of whether survivors of sexual abuse should be compensated or be dealt with in the most fair and sensitive fashion. It's the way in which it's being proposed that is going to be problematic for the colleges to implement.

**The Chair:** Thank you very much for coming before the committee. Again I apologize for the lateness of the hour, but we appreciate you staying to make your submission.

The committee will stand adjourned until next Monday, November 29, at 3:30 pm.

The committee adjourned at 1848.







*Continued from overleaf*

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York North/-Nord L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

Rizzo, Tony (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Haeck, Christel (St Catharines-Brock ND) for Ms Carter

Harrington, Margaret H. (Niagara Falls ND) for Mr Owens

Haslam, Karen (Perth ND) for Mr Hope

Wessenger, Paul (Simcoe Centre ND) for Mr Martin

### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to the Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Services

## CONTENTS

Tuesday 23 November 1993

<b>Regulated Health Professions Amendment Act, 1993, Bill 100, <i>Mrs Grier</i> / <b>Loi de 1993 modifiant la Loi sur les professions de la santé réglementées, projet de loi 100, <i>M<sup>me</sup> Grier</i></b></b>	S-537
Ad Hoc Coalition of Regulated Healthcare Associations on Bill 100	S-537
Signe Holstein, coalition co-chair and executive director, Ontario Chiropractic Association	
Dr Wendy Graham, member, committee on sexual abuse, Ontario Medical Association	
Dr Bob Haig, chair, Bill 100 committee, Ontario Chiropractic Association	
Pam Fitch, president, Ontario Massage Therapists Association	
Ontario Physiotherapy Association	S-544
Beverley Lafoley, president	
Cheryl Kirkness, member	
Ontario Psychological Association	S-546
Dr Ruth Berman, executive director	
Dr Iris Jackson, past president	
Dr Carole Sinclair, member, ethics and policy committee	
Coalition of Regulatory Colleges	S-548
Dr Catherine Yarrow, acting registrar, Ontario Board of Examiners in Psychology	
Sharon Saberton, Board of Radiological Technicians	
Jane Rogers, Transitional Council of Dental Hygienists,	
Janet Ecker, director, research and policy analysis, College of Physicians and Surgeons of Ontario	
College of Audiologists and Speech-Language Pathologists of Ontario	S-550
Barbara Meissner Fishbein, member, transitional council	
Ontario Chiropractic Association	S-552
Janice Hughes, secretary-treasurer	
David Chapman-Smith, legal counsel	
Board of Directors of Chiropractic	S-554
Dr Edward R. Burge, chair	
Jo-Ann P. Willson, director, policy analysis and research	

*Continued overleaf*



C1001  
XC12  
-577  
S-24



S-24

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 29 November 1993

# Journal des débats (Hansard)

Lundi 29 novembre 1993

## Standing committee on social development

## Comité permanent des affaires sociales

Regulated Health Professions  
Amendment Act, 1993

Loi de 1993 modifiant la Loi  
sur les professions de la santé



Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 29 November 1993

The committee met at 1538 in room 151.

REGULATED HEALTH PROFESSIONS  
AMENDMENT ACT, 1993

LOI DE 1993  
MODIFIANT LA LOI SUR LES PROFESSIONS  
DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 100, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 100, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

**The Chair (Mr Charles Beer):** Ladies and gentlemen, we begin our hearings on Monday, November 29, on Bill 100, An Act to amend the Regulated Health Professions Act, 1991. We have a very full schedule for this afternoon and this evening.

If I could just note for members and for those in the audience, we will have to go to a vote at approximately 5 o'clock, but that will not affect the time allocated to everyone, although it may affect whether we get to you quite at the time that's set on the schedule. But I think there's a bit of flexibility in it and I just would say again that everyone who is to be heard today, this afternoon and this evening will be heard and we'll try to minimize the time when we have to be out of this room.

CANADIAN BAR ASSOCIATION—ONTARIO

**The Chair:** Without further ado, then, I call upon our first witnesses, from the Canadian Bar Association—Ontario. If you would be good enough to come forward and identify yourselves for Hansard and for the committee, I'll just note that there's one person there who has often been at a different part of the table. We welcome you back to the committee, Linda.

**Ms Linda Bohnen:** Thank you.

**Mr Tony Caldwell:** Mr Chair, members of the committee, my name is Tony Caldwell and I am a member of the executive committee of the health law section of the Canadian Bar Association.

Ms Linda Bohnen is with me, as you're well aware. She also is here in the capacity of an executive member of the health law section of the Canadian Bar Association. Also with us is Ms Joan MacDonald, who is a member of the feminist legal analysis committee, which is a section of the Canadian Bar Association.

The written document which is before you is a joint submission on behalf of both the health law section and the feminist legal analysis committee.

Following my introduction, Ms Bohnen will deal with the issues of the definition of "sexual assault," the participation in discipline hearings and in that process, and the cost aspect of the submission. Ms MacDonald will then deal with mandatory reporting.

The purpose of this submission is to provide the standing committee on social development and the Minister of Health with comments on important legal

policy issues raised by the Regulated Health Professions Amendment Act, 1993.

While the Canadian Bar Association supports the overall objective of Bill 100, which is to try to prevent sexual abuse of patients by health professionals and to deal with it appropriately and effectively when it occurs, the Canadian Bar Association is concerned that this laudable objective not be achieved at the expense of other principles that our society cherishes.

We believe that we must be especially vigilant when a statute grants extensive powers to agencies of government and when the exercise of these powers may have a significant impact on individual rights. Regulatory colleges established under the Regulated Health Professions Act are agencies of government and the exercise of the powers granted to them under both the 1991 act and the act under consideration now will have a significant impact on the livelihood, reputation and personal property of these regulated health professionals.

The CBAO therefore wishes to bring to the attention of the standing committee on social development several features of Bill 100 that we find especially troubling.

**Ms Bohnen:** It's nice to have the opportunity to try to influence the legislation from this side of the table.

I'd like to start by commenting on the definition of "sexual abuse" in the bill. As you will have observed, it's an extremely compressed definition that is expected to cover a very wide range of behaviour that occurs in a wide variety of professional relationships. It's important that this definition be an apt and appropriate one, because the strength of the bill proceeds from that definition.

Firstly, it is for this reason that we don't support the government amendment that has been tabled that would remove subsection 3(4) from Bill 100. That subsection would give college councils the authority to make regulations that clarify or extend the statutory definition of "sexual abuse." We think this authority is necessary, because it's unrealistic to think that a single statutory definition could adequately define a matter as complex as sexual abuse, especially when we remember that this legislation applies to 24 regulated health professions. Colleges must be able to make regulations to ensure that the definition is applicable to their members, their members' scope of practice and the nature of their relationships with their clients and patients.

We do support the government amendment to amend the third element of sexual abuse, which relates to remarks and non-physical behaviour of a sexual nature, to that which is "demeaning, seductive or exploitative." We think this is a very positive step that will enable everyone to understand just what is offensive.

But other refinements are necessary as well, and we'd like to bring to your attention our view that if the relationship between a patient and a professional is not characterized by trust and dependency, then a sexual



relationship outside the treatment setting may not be inherently abusive in the case of every regulated health professional; rather, it will depend on whether or not there is exploitation.

For these reasons, we propose the definition that you find on page 2 of our written submission, which would include in that definition the issue of exploitation, so that sexual abuse would mean any act of a sexual nature in which the member exploits the patient, and then include the three elements that you see here.

The significant changes lie in (a) touching of a sexual nature without the patient's consent, ie, sexual assault, and (b) sexual intercourse, other forms of physical sexual relations and touching where, as a result of the professional relationship, the patient is in a position of trust and dependency.

Again, we believe this statutory definition should be supplemented by profession-specific regulations. A college council might, for example, make a regulation that prohibits all physical sexual relations between members of the profession and patients on the basis that relationships between members of that profession and their patients are always characterized by trust and dependency. Such a regulation could also address the period of time during which an individual is considered to be a patient because of continuing emotional dependency on the professional even after purported termination of the professional relationship.

I'm going to turn to the issue of participation in discipline hearings, which starts on page 3 of our written submission. As you know, right now the parties to a discipline proceeding are the professional and the college. Bill 100 would enable the panel of a discipline committee to permit non-parties to participate when in the panel's view that would be of assistance to it or where the non-party's good character, propriety of conduct or competence is at issue.

We think this is a mistake because it will pose an unacceptable risk of procedural injustice to accused professionals, and that risk is enhanced by the fact that the section provides virtually no direction to committees as to how their discretion to permit participation should be exercised. Nor does it provide that the fairness of the hearing must be the paramount consideration. Equally importantly, it poses the risk of confusing and therefore weakening the college's case, resulting in acquittals of members charged.

We do, however, strongly support the use of victim impact statements and we believe that the patient should have the option of making an impact statement orally or in writing, or both. For that reason, we would recommend a small amendment to the government-tabled amendment to subsection 11(3) of the bill to permit either oral or written impact statements, or both, at the option of the patient.

Costs: Bill 100 would authorize the discipline committee panel to order a professional who is found guilty of professional misconduct or incompetence to pay part or all of the college's legal costs. However, under section 53 of the existing act costs can be awarded to a professional only where the panel finds that the commencement of the

proceedings was unwarranted. Under the tabled amendment, costs could be awarded against a professional in any circumstance and those costs could include legal costs, investigative costs and hearing costs. It's true that the general rule of civil proceedings is that legal costs are awarded to a successful party.

We think that whether this rule should be applied to college disciplinary proceedings is too important and large an issue to be resolved in the context of these hearings. Discipline proceedings are penal in nature and the member has little choice about being involved in a discipline proceeding. This is especially true in today's climate when the complaint is one of sexual abuse. The resources of a college far outweigh the resources available to individual practitioners and we therefore think that the prospect of an order for costs is sufficient to propel innocent practitioners to plead guilty.

Finally, we are even more alarmed by the proposition that a more restrictive test for awarding costs should be applied to professionals than to colleges. There's simply no justification for this.

My colleague will now address the issue of mandatory reporting.

**Ms Joan MacDonald:** Bill 100 requires a report to be filed with the appropriate regulatory college when a regulated health professional or the operator of a facility in which one or more regulated professionals practise has reasonable grounds to believe that a professional has sexually abused a patient. The requirement applies to all forms of sexual abuse, including remarks and other non-physical behaviour of a sexual nature. A report must be filed regardless of the wishes of the patient who was the target of the abuse, although the patient cannot be named without his or her consent.

The Canadian Bar Association—Ontario believes that mandatory reporting of remarks is offensive in a free and democratic society that cherishes both the freedom to speak and the freedom to be silent. The erosion of that freedom is not balanced by the benefit likely to be obtained from this requirement. Certainly, if the victim of the abusive remark does not wish to make a complaint and does not consent to being named in the report, the report will be of inconsequential use to the college. We believe that the requiring of a report to be made against the wishes of the victim serves to disempower survivors and, in a sense, to re-enact the original abuse. We therefore recommend that the mandatory reporting provisions of Bill 100 be amended not to apply if the victim does not consent to the report.

**1550**

What this committee may find is that if Dr Jones has a complaint issued against him some 15 years down the road and there are three previous unnamed complaints, then it may be that by due process the unnamed people requiring to remain unnamed are pulled into the current action as of the day of the complaint. I think the committee has to be very concerned about not revictimizing the victim.

As long as the health professional obtains the grounds for believing abuse has occurred in the course of practis-

ing the profession, a report must be filed; and no exception is made for regulated health professionals involved in treating other regulated professionals. In fact, where the treatment involves psychotherapy, the report must include an opinion, where possible, as to whether the abuser is likely to continue the abuse. The treating professional must file a further report if the abuser discontinues therapy. The CBAO believes that these requirements are an egregious violation of the privacy rights of professionals who seek treatment and that they are almost certain to deter professionals from seeking treatment.

In addition, this reporting requirement will complicate the obtaining of psychological and psychiatric assessments on health professionals involved in civil or criminal proceedings. The unfairness of the reporting requirement is heightened where the assessment has been court-ordered. There are many competing interests in this legislation.

Finally, the CBAO believes that where an agency is authorized to collect mandatory reports on individuals that contain highly damaging allegations, it is imperative that statutory direction be provided as to the opportunities for the correction of the information and as to the use, retention and destruction of the reports. Provisions of this type appear in the children's and family law reform act in relation to child abuse reports. The CBAO urges that similar provisions be added to Bill 100.

From the feminine legal analysis perspective, we are concerned that when a patient enters a therapeutic relationship with another therapist there should be some consideration to the patient's wishes as to whether that patient requires that the matter be reported. Unfortunately, human beings do not always operate on the time clock of 30 days. It may be detrimental to the patient to report within the time frame desired. There could be a revocation by the therapist in question who is presently treating the patient that would protect both individuals in that relationship.

**Ms Bohnen:** We'd like to stop there with our final, concluding comment that we support the overall thrust of Bill 100. We think the issues we have raised significantly impede the likely effectiveness and fairness of the bill and that amendments are called for to make the improvements that we've discussed.

**The Chair:** Thank you very much. Unfortunately, we don't have a lot of time for questions.

**Mr Jim Wilson (Simcoe West):** A very good presentation; I thank you for it. I wanted to ask Ms Bohnen to clarify a point made on page 4. It's two sentences under the section entitled "Costs." It says: "We are even more alarmed by the proposition that a more restrictive test for awarding costs should be applied to professionals than to colleges. There is simply no justification for this." Could you just elaborate on that point for me?

**Ms Bohnen:** Sure. By way of background, under the Health Disciplines Act there is no authority for costs to be awarded to either the college or the practitioner who is the subject of a discipline hearing. An amendment to the Health Disciplines Act that appears in the Regulated Health Professions Act, 1991, permits the panel of a

discipline committee to award legal costs to the practitioner if the practitioner is acquitted, so to speak, only if the panel finds that the commencement of the proceedings was unwarranted; ie, that it never should have brought disciplinary proceedings against this member.

As amended in the government proposals, the discipline committee would be given the authority to require the practitioner to pay costs to the college if the practitioner is convicted of professional misconduct or incompetence. There is no rider that, for example, the member unduly prolonged the hearings or complicated the hearings or didn't cooperate in some way. The member can only get costs if the proceedings never ought to have been brought against him to begin with, whereas the college can get costs—and I might add that those costs include the hearing costs and the investigative costs as well as the legal counsel fees—in any situation where the member is convicted of professional misconduct. We don't see any valid justification for a more restrictive test in giving costs to the member.

**Mr Jim Wilson:** I guess the problem arises in terms of some of the smaller colleges. If they don't have the ability to evoke this cost recovery scheme, given that the fines go to the province, they may go belly up.

**Ms Bohnen:** As you've suggested, one possible solution is to permit the fines or a portion of them to go to the colleges. There are existing small colleges or small governing bodies under the statutes that have preceded the RHPA. Even though these colleges are small, they do have more resources than individual practitioners, and when you're pitting the might of a state agency against the might of an individual practitioner, the CBAO believes that the balance has to be tipped in favour of the practitioner. Of course, what the college will have to do is increase all the annual fees payable by its members to pay for its ongoing costs.

**The Chair:** Mrs Haeck, I'll permit one short, final question.

**Ms Christel Haeck (St Catharines-Brock):** Hello again, Ms Bohnen, and hello to your colleagues. An interesting presentation, but I want to approach this from the consumer survivor bent for a moment. There was a 60 Minutes television broadcast this week talking about some doctors in emergency medicine. I understand that the situations are different; however, they talked about a particular doctor who in fact had come up against a charge of sexual misconduct with a patient in one jurisdiction and then managed to move around and it took a while to catch this particular individual.

If there had been no record, and likewise, if there seems to be a pattern that is established, what you're suggesting is that even a professional, someone else who was working with that person and happens to see a particular pattern of conduct and the victim of that conduct feeling, for a range of reasons, not quite capable of coming forward—I would think that it really would behoove a professional who was working with the perpetrator to at least establish that there is a problem. It would be, I would think, important for a college looking at this to be able to establish over the long term that, just because someone all of a sudden had the emotional



wherewithal to address this issue some years after this person started this particular behaviour, there is a history to this.

What you're suggesting is that we wait for only so long until that one person has that internal strength to be able to deal with that. My personal feeling is that I realize that, even dealing with it from a labour relations point of view, you do have to establish that there is some sort of cause for an action. I believe this particular clause and the subsections thereto establish cause.

**Ms Bohnen:** When the alleged abuse occurs in an institutional setting, as it would for emergency room physicians, for example—

**Ms Haeck:** That's just a very recent example.

**Ms Bohnen:** Sure—there are other mandatory reporting requirements in the RHPA that would trigger a report to the college. Where someone loses privileges, their employment is terminated or they are permitted to resign. There is also, of course, voluntary reporting by patients, onlookers and other health care professionals, because the RHPA does not restrict who may make a complaint or file a report on a voluntary basis. But to come down to the crux of the issue, which is what do you do when a health professional has information that a patient has been sexually abused and the patient does not want the report made, that's where we come to the policy crux.

1600

**Ms Haeck:** I think having their name used is probably more at issue.

**Ms Bohnen:** I don't believe that's the case. Some of them are quite prepared for the reports to go ahead; they do not wish to be named. Others don't want the report to go ahead whether they are named or not named.

What we're saying, and what my colleagues from the feminist legal analysis section say, is that to permit a report to go ahead where the patient who is the victim of it does not want that report made, in our view and their view, is the wrong policy choice because it revictimizes and disempowers victims of sexual abuse, survivors of sexual abuse.

**Ms Haeck:** We can discuss this in the hallway.

**The Chair:** Yes, because of time; I'm sorry. I wanted to allow some questions, because this is I think the only presentation dealing directly with specific legal issues from the Canadian Bar Association, but I'm afraid if we go any further, we're going to be here till midnight. Thank you very much for coming before the committee and for your submission.

**Ms Bohnen:** You're welcome. If I could just make one plug for the Canadian Bar Association, our sections are available to you if you have any supplementary questions that there isn't time to deal with today. We'd be happy to be contacted by you.

**The Chair:** Thank you very much.

COLLEGE OF NURSES OF ONTARIO

**The Chair:** I next call upon the representatives from the College of Nurses of Ontario, if you would be good enough to come forward. Welcome to the committee and please make yourselves comfortable. If you would be

good enough to introduce yourselves for Hansard and the committee, then please go ahead. We have a copy of your submission.

**Ms Pat Mandy:** My name's Pat Mandy. I'm the president of the council of the College of Nurses. On my left is Anne Coghlan, who's the vice-president, and also with us is Elisabeth Scarff, the director of policy analysis and development.

The College of Nurses welcomes this opportunity to submit our comments to you. Many of our concerns and proposals with respect to this bill were identified last week by the Coalition of Colleges and Transitional Councils, of which we are a member. Our submission today focuses on issues of particular concern to the College of Nurses.

The College of Nurses is a statutory body governing 110,000 registered nurses and 35,000 registered nursing assistants in the province of Ontario. The mission of the college is to regulate nursing to protect the public interest.

There are three specific considerations that have steered our response to the bill. They are the eradication of all forms of abuse by health professionals, the need for workable legislation and the requirement for integrity and fairness in the discipline process.

The prevention of abuse of clients by health professionals is a responsibility of all regulatory bodies, but this responsibility is not, and should not appear to be, limited to the prevention of sexual abuse. The College of Nurses believes that abuse of any nature, whether it be physical, emotional, verbal or sexual, must be prevented.

Furthermore, we believe that a number of provisions of the bill are likely to act as a barrier to the achievement of this goal. No legislation can be effective unless it can be implemented and enforced. In other words, it must be workable.

This means that it must be capable of being implemented and enforced in a timely and cost-effective manner; there should be a strong likelihood that the basic elements of the legislation will be sustained in the courts, bearing in mind the intense scrutiny for compliance with charter rights and principles of natural justice to which all disciplinary actions are subject; and there must be significant voluntary compliance with the reporting requirements. This in turn means that the legislation must be easily understood and have credibility with the public and with health professionals.

Finally, the efforts to strengthen the ability of colleges to prevent and punish abuse should not threaten the integrity of the regulatory process. This is likely to occur if the legislation attempts to extend professional regulation to duplicate or replace the criminal or civil justice system by expanding the basic issue from the standards required to practise a profession to matters of retribution and recompense. It will also occur if it imposes functions or activities which limit the actual and/or the appearance of fairness and objectivity in the exercise of quasi-judicial functions.

Bill 100 as it's currently proposed raises some concerns. First, the scope of the legislation: The College of



Nurses regulates a large and predominantly female profession. About 97% of RNs and RNAs are female. As such, our commitment to those elements of Bill 100 which we believe will help prevent sexual abuse of clients is unconditional. But the fact that sexual abuse is the sole focus of Bill 100 infers that other forms of abuse are of a lesser importance. This is a view that the College of Nurses strongly disputes. The goal of prevention of all forms of abuse should be clearly articulated in the legislation.

Our second concern relates to the definition of "behaviour or remarks of a sexual nature" and their mandatory reporting. These are two issues that should be considered jointly. The implications of these provisions on the workability of the legislation are significant. There must be a common understanding among regulated health professionals, the public and the courts of what behaviour or remarks are sexual in nature.

The whole realm of behaviour or remarks of a sexual nature is highly value-laden and subjective and is closely tied to cultural and social perspectives. There are more than 200,000 regulated health professionals in Ontario, all from diverse cultural and professional backgrounds. Guidance about the meaning of "sexual nature" is essential.

Bill 100 sets out strict liabilities and penalties both for committing such an act and for not reporting it if the member becomes aware of the act. If a significant portion of health professionals are uncertain about what remarks or behaviour are considered to be of a sexual nature, their predominant concern is likely to centre on their personal liability, rather than on addressing the abuse itself.

The combination of a vague definition and mandatory reporting requirements is likely to result in a barrage of reports which will be administratively cumbersome and will impose unrealistic demands on the time and commitment expected of council members, as well as the funding base of many colleges.

Alternatively, the same combination may produce another group of members who will take the view that if there's uncertainty about what remarks or behaviours are subject to mandatory reporting, the best recourse may be to avoid the issue altogether, leaving the incident unaddressed and undermining the credibility of the legislation.

Furthermore, the legislation seems to ignore the reality that the vast majority of regulated health providers work in an employment setting. It's our view that there is a role for employers in educating and preventing abuse and surely there are many occasions in which the matter can be dealt with more effectively in the employment setting.

The college's ability to deal expeditiously with serious cases of abuse will be compromised by removing any discretion in the member being able to report to an employer. Reporting of all forms of abuse, including behaviour and remarks of a sexual nature, must be promoted.

Failing to provide guidance around the parameters of the definition of "sexual nature" and reporting of behaviour and remarks and making reporting of behaviour and

remarks mandatory in all incidents, however, does threaten the enforceability of the legislation.

The third issue that we want to flag relates to the funding of counselling for survivors. The basic premise that it is appropriate to transform regulatory bodies into funding bodies is one that the College of Nurses does not accept. These services should be accessible directly or indirectly as part of universal health care.

We recognize that the government, however, is likely to remain firm in its intent to require colleges to provide funding for therapy and counselling and if so, what we would urge this committee to evaluate carefully is the fact that having the Patient Relations Committee administering the funding program constitutes a fundamental conflict of interest for the colleges. The same party that is determining whether or not misconduct has occurred is responsible for payment in the event of a finding that it has occurred. This is a clear conflict with one of the founding principles of administrative law, that judicial and quasi-judicial functions must be impartial and must appear to be impartial.

The College of Nurses believes that any funding program must be administered at arm's length from the college in order to preserve the integrity of the hearing process. The provision that the program is to be administered by the Patient Relations Committee should be deleted.

#### 1610

The final issue we want to highlight today relates to non-party participation in the disciplinary hearing. The College of Nurses supports codifying the discretion of a discipline panel to allow a person who is not a party to the hearings to appear before the hearing. It serves to emphasize for all parties that this is available. We are aware, however, that you have been or are likely to receive submissions asking for automatic rights of participation. We have grave concerns that such rights will severely compromise the manageability of the disciplinary process.

Regulatory bodies and complainants do not always have the same interests. Preserving the strict standards of fairness becomes even more problematic if there are third or fourth parties pursuing their own interests in the same hearing. It is arguable that granting automatic participation rights to third parties would move a regulatory body from being an arbiter of professional conduct to an arbiter of justice.

For these reasons, the College of Nurses supports maintaining codification of the discretionary right to allow participation as set out in the first reading of Bill 100.

In conclusion, Bill 100 is an important piece of legislation which is supported by the council of the College of Nurses of Ontario. In considering the degree of mandatory requirements to be imposed by the bill, it must be recognized that legislation can only be one element in the effort to eliminate abusive clients by regulated health professionals. The threat of penalties under the bill should represent the last resort, not the first. Our focus should be on prevention and not punish-

ment after the fact, and effective, timely disposition of discipline hearings.

**Ms Haeck:** Thank you very much for an extensive brief. You've obviously done a lot of work on this particular issue. I, along with a number of my other colleagues sitting in this room, had a chance to listen to some presentations this morning, relating to violence against women, by the Ontario Association of Interval and Transition Houses. They're speaking mainly about spousal abuse of women, and yet again you mention a number of things that they've also brought forward. It relates to cultural differences.

I'm concerned that in your brief you mention that how people respond to these issues may be different. Are you referring to how a doctor may speak to a woman from a different cultural background than ourselves and how that may be taken, or are you referring to a doctor who may have a somewhat different cultural background and how, say, you or I might respond to that?

**Ms Mandy:** First of all, we're mainly talking about nurses. But we're talking about the fact that there are a lot of clients or patients from various cultural backgrounds who may perceive the intent as different than what was meant in a procedure or discussion.

**Ms Haeck:** Would you agree, as the women did this morning, that cultural and racial sensitivity programs would be of value in the health care sector, as others are advocating for the judicial system?

**Ms Mandy:** Yes. In fact, in our strategic plan for the College of Nurses for the next year, one of the major thrusts is cultural sensitivity and awareness.

**Mr Jim Wilson:** Thank you very much for your presentation. There's a line on page 10 that says, "CNO fundamentally disagrees with the principle that sexual abuse imposes greater rights on complainants than other forms of abuse." I'm going to ask you to comment on that. It leads into the section where I think you are correct, and I spoke at length in the House on this during the closure motion, with respect to the inherent and rather transparent conflict of interest with respect to the Patient Relations Committee administering the funding and the whole process.

Can you just comment briefly on those two issues? What's the solution with respect to, particularly, who should administer this process?

**Ms Mandy:** I was reading while you were talking to try to find the thing in here. Were you asking—

**Mr Jim Wilson:** It's a big question with respect to this. I find it rather an astounding statement that on page 10, in the area of sexual abuse—this legislation, I guess you're saying, implies that the complainants have greater rights with respect to this issue area.

**Ms Mandy:** Mainly because it's focusing on sexual abuse and we have as many concerns about other forms of abuse, such as physical abuse, verbal or emotional abuse, and feel that they should be included as well as sexual abuse.

**Mr Jim Wilson:** So fundamentally you think the definition doesn't encompass enough of the abuse that's currently going on out there?

**Ms Mandy:** It's focusing on sexual.

**Mr Jim Wilson:** Secondly, what's the solution with who should administer this process if not the Patient Relations Committee?

**Ms Elisabeth Scarff:** We don't have a precise answer for that at the moment. Obviously, our preference would be that it would be completely at arm's length and would be some sort of government-funded, arm's-length agency. Short of that, I think colleges need to have the discretion to be able to assess what mechanism they can provide for themselves that would be at arm's length. But as long as the provision is that the Patient Relations Committee is going to administer it, it limits even our own ability to canvass what options may be available to allow us to be at arm's length.

**Mr Jim Wilson:** Just back to the definition, you'd be in favour then of keeping in 3(4), which follows the definition of "sexual abuse" in the consolidated bill and talks about allowing the colleges to make regulations clarifying the definition?

**Ms Mandy:** Yes.

**The Chair:** Thank you very much for coming in today and for your presentation.

#### SPIRICOASIS

**The Chair:** I call on our next presenter, if I pronounce this correctly, a representative from Spiricoasis.

**Mr Alex Perlman:** You pronounced it correctly.

**The Chair:** If you'd be good enough to introduce yourself, then please go ahead with your submission.

**Mr Perlman:** My name is Alex Perlman. I should initially clarify what might lead to some confusion. Of the two documents that I gave you, one is a letter that I sent to the then Health minister in January of this year and it's sent from Interaction Network. I have several organizations I'm involved with. The second piece has my name on it, so however you want to organize those.

I'd like to start by saying that I'm pleased to be here as part of the practice of democratic process in our province. I understand that there are 15 minutes allocated for this presentation. I'd like to request that, as what I see as being the democratic process, I'll be taking about five minutes to present what's in those two documents you have and I'd be very happy to answer your questions, and I'd like to also have a third element, which is I'd like to hear what your views and reactions are to what I've said so that we can engage in some dialogue within the limited context of the time that we have. I'd like to know if that sounds acceptable to the members here.

**The Chair:** We have 15 minutes and we'll use it however the questioning goes on.

**Mr Perlman:** Great. I'll start with the letter I wrote to the Health minister in January, which I think expresses my views quite succinctly, and then the other document provides some recommendations.

"This letter is written to bring to your attention concerns over the proposed amendments to the Regulated Health Professions Act. As you know, the amendments prohibit any form of sexual interaction between a health practitioner and a patient of said practitioner.



"In over 16 years as an educator in the field of human relations, I share your view that sexual abuse is unacceptable, whether it take place in the health professions or elsewhere. Unfortunately, the legislation as it is currently conceived protects the rights of those who are potential victims of sexual abuse by imposing regulations which violate the rights of other citizens.

"The task force on sexual abuse which reported to the Ontario College of Physicians and Surgeons asserted the view that any and all sexual interaction between a physician and a patient is sexual abuse. The proposed legislation also is predicated on this view. The sole argument for this view is the assumption that no patient has the ability to give informed consent to sexual relations with the physician—or other health practitioner—"due to the inherent power imbalance of the relationship. While this dynamic is undoubtedly true in many cases of sexual abuse, great caution must be taken if one is to draw the same conclusion on behalf of all members of the population of potential patients.

"For various reasons, it is true that there are physicians who conduct themselves as authority figures presiding over patients as opposed to conducting themselves as unassuming advisers to patients. Similarly, it is true that there are patients who allow themselves to fit into a complementary role of submission. This dynamic is one which is a result of a number of factors including the tradition of respect for and submission to figures of authority. This tradition is predominantly supported by our current educational and judicial systems.

1620

"Imposition of authority is required where an individual makes choices which violate the rights of others. However, no authority in a democratic system has the right to impose its values on members of our society where the choices of those members are not in violation of others. Specifically, the government of Ontario has no right to impose on our society personal values which hold that a patient and his or her health practitioner must not engage in sexual relations. The proposed legislation protects the rights of potential victims of sexual abuse without concern for the valid rights of other citizens to make their own self-determined choices regarding with whom they are to engage in mutually consenting sexual relations.

"The assumption that no citizen of the province of Ontario is capable of making informed consensual decisions in relation to his or her health practitioner is not only an insult to the intelligence and autonomous capability of each citizen, but its implications as the basis for government policy are dangerous in the extreme.

"I urge you to reconsider and redraft the legislation so that it's effective in protecting the rights of all citizens of Ontario in relation to their health practitioners. Properly drafted legislation will protect those who fall victim to sexual abuse as well as those who would choose with full good conscience and awareness based on their own personal value systems to engage in mutually consensual sexual relations with persons who happen to be their health practitioners."

This other document I have here provides three

recommendations following from this letter and I'll read through those.

The first is to provide that any person may sign a waiver which exempts his or her health practitioner from the specific sexual abuse regulations to be implemented by the bill and to rely solely on the laws which govern sexual assault by any member of Canadian society. Such a waiver is to be effective only in regard to health practitioners for which the person signing the waiver becomes a patient after the date of signing. A person couldn't sign this waiver after having gotten to know the physician.

The second is to provide that all patients, whether having signed a waiver or not, have the opportunity to engage in a relationship with a health practitioner after undertaking appropriate educational and counselling prerequisites offered by a qualified third party to ensure that it isn't a situation of sexual abuse or potential sexual abuse.

The third recommendation is to provide that all patients and health practitioners have the right to engage in social interaction provided that such interaction involves no sexual content or interaction of a sexual nature. I understand that the current wording would prohibit any kind of social interaction, even going out to dinner, between a patient and a doctor.

That's what I want to present. I'd like to address your questions and find out what your reactions are to the points I've made here.

**Mr Stephen Owens (Scarborough Centre):** Let me tell you, my first reaction is that your presentation is certainly a lot different from anything else I've heard on this issue during these hearings or at any other point when this issue has arisen.

I guess I should preface my question to you with a comment that I don't believe a physician's office, a psychotherapist's office or a dental practitioner's office should serve as a dating service for either the practitioner or the patient. I think that the position of trust the practitioner is in renders the opinion of yourself and others who may be involved with this particular opinion to be a little bit absurd. Any kind of activity such as you suggest is completely inappropriate and antithetical to any kind of oath that practitioners would take with respect to the service they are to render to their patients. I don't understand—

**Mr Perlman:** I'd like to respond to your comment, if I may. I know you said you were going to ask a question, but you started with a reaction, which I appreciate, and I'd like to respond to that, if I may.

**Mr Owens:** It's your 15 minutes. Go ahead.

**Mr Perlman:** Thank you. I see this as our 15 minutes, by the way. I see us all as serving all of the citizens of Ontario and I think it's important to recognize that.

I feel personally affronted when you say my opinions are absurd and I want to also say that I appreciate your honesty. You've said you don't believe that a physician's office or other health practitioner's office should serve as a dating service. I agree, an office is not set up for that purpose, but I'd like to bring it to a very personal



situation. If I go into a doctor's office—say, my family practitioner refers me to another doctor—and I meet this person, it happens to be a woman, she attends to whatever my needs are and there is a dynamic there where this is the person I've been looking for all my life and there's a connection and real value to pursuing a relationship with this person, what you're telling me is that there is no right for us to pursue that relationship.

I'm fighting for that right as a citizen of Ontario and as a person who's responsible for my own choices. I don't see that as being absurd. I see that as being an inherent right that I have as a citizen of this province and I don't believe the government has the right to restrict that type of relationship.

You were going to ask me a question and I did want to respond.

**Mr Owens:** I don't understand, first of all, where you would draw the line. I guess that's the first question: Where do you draw the line? How do you determine other than some kind of a waiver that's signed? I'm just wondering if you've ever heard of the word "coercion," if you are aware of the power relationships between men and women. You talk about yourself as a male wanting to have a relationship with your female physician, but in my experience, again, with this particular issue, there's usually a power relationship that takes place between a physician and his female patient. This is where the problem lies.

**Mr Perlman:** I'd like to answer your question. I absolutely recognize that this is the situation that is being addressed here and that's why the Task Force on Sexual Abuse of Patients said that any relationship between a physician and a patient is sexual abuse. They're saying that the patient can't consent because there is this power dynamic. What I'm saying to you is that yes, there are many people who are, if I may say, immature in that they see the doctor or other health practitioner as being a great power and they would be subject—I see you shaking your head.

**Mr Owens:** That's right.

**Mr Perlman:** Please just try and understand what I'm trying to say.

**Mr Owens:** I understand clearly what you're saying.

**Mr Perlman:** Okay, tell me what I'm saying.

**Mr Owens:** I just disagree with it fundamentally—

**Mr Perlman:** What is it that you disagree with? What am I saying?

**Mr Owens:** —in terms of your assertion that one can make a "mature" choice with respect to this type of a situation. I just don't think that your suggestion is reasonable.

**Mr Perlman:** You're saying to me that no person in our province is capable of making that decision?

**Mr Owens:** That's not what I'm saying at all.

**Mr Perlman:** I'm trying to protect the people who are capable of that.

**Mr Owens:** And I'm trying to protect the people who have been seriously disadvantaged and hurt by the lack of understanding.

**Mr Perlman:** Absolutely. That's what this legislation is for. I'm saying draft legislation which protects those people without violating the rights of those people who are capable of making that decision.

**Mr Owens:** Then you must be a much wiser person than I, because I certainly can't begin to devise, or even want to think about setting up, a system that would determine who was capable or not capable of making a decision with respect to relationships with their practitioners.

**Mr Perlman:** I've provided a proposal here which provides for those individuals prior to meeting a practitioner, where they can sign such a waiver. I think the biggest problem with sexual abuse in the health professions involves the hidden relationship. If it's out in the open, the second provision provides that where people are interested in a relationship, they go to a third party who would have the responsibility to determine.

If you can think of a better way, fine, but what you're saying to me is there's no way to do it, therefore my rights as an individual must be violated. Barring totally disregarding the licence of the health practitioner, I'll have no right to engage in such a relationship. I'm not saying to you that I will choose to do so. What I'm saying to you is that, as a premise, it's very dangerous. What we're doing is bringing the legislation down to the lowest common denominator. In other words, the most helpless person will be protected by this legislation and those people who are self-responsible and can make informed decisions on their own will not have the right to do so.

I've been engaging with one member here. I wonder if others have varying opinions.

**The Chair:** Have you finished your questioning?

**Mr Owens:** Absolutely.

**Mr Perlman:** We've got a minute and a half left.

**The Chair:** That was the only question that was on the docket. Thank you very much for coming before the committee.

**Mr Perlman:** So I don't get my—okay.

**The Chair:** There are no further questions. Thank you very much for coming before the committee.

**Mr Perlman:** I just requested other reactions, but if you're saying my time is up, then I accept that.

**The Chair:** No, I'm just saying that there are no further questions. Thank you very much for coming before the committee.

**Mr Perlman:** I would like to state before this committee—

**The Chair:** Order, please.

1630

ONTARIO MEDICAL ASSOCIATION,  
SECTION ON PSYCHIATRY

**The Chair:** I would then call on the representatives from the section on psychiatry from the Ontario Medical Association. Please come forward. Would you please introduce yourselves. We have a copy of your submission. Please go ahead.

**Dr Patrick Conlon:** Good afternoon, members of the

committee. My name is Dr Patrick Conlon. I'm a psychiatrist from Goderich, Ontario. I am chairman of the Ontario Medical Association section on psychiatry. With me is Dr Judith Hamilton, a psychiatrist from Toronto with a special interest in the practice of psychoanalysis and also a member of our section executive and chairman of our section's response to Bill 100.

We are here today to give our support to the efforts to date in addressing the problem of sexual abuse of patients by health care professionals. Already, by acknowledging and recognizing the problem, the education of our colleagues and the public has commenced. Already, increased awareness has led to a marked increase in the reporting of sexual abuse.

Health professionals guilty of abuse are now more likely to be identified and disciplined. Most importantly, patients who have been victims of abuse are heard and hopefully now will be dealt with in a more compassionate way. This evolving process serves us all well. Public and professional awareness, however difficult the debate, must be the cornerstone of any effective strategy dealing with the problem.

Psychiatrists, like other health professional groups, have had some time since the original task force recommendations to reflect, analyse and debate the proposals. This dialogue has been healthy for our profession. We are all now in a position to carefully consider provisions to not only protect but also preserve the integrity of patients.

Therefore, it is incumbent upon legislatures and legislators to recognize the complexity of this issue and propose workable solutions taking into consideration the needs of all patients. It will not be good enough to propose regulations solely because they are simple to understand or apparently easy to administer, and certainly it will be completely unacceptable to propose legislation that harms some patients even if the greater good seems to be served, particularly when this in fact need not be the case.

Psychiatrists have great concern for the wellbeing of their patients. It is a responsibility we do not take lightly. Therefore, we have tried to approach this issue in a constructive manner. We feel that with some modification the current proposals, particularly those related to mandatory reporting, can benefit all patients.

I therefore urge you to listen carefully to the presentation of my colleague Dr Hamilton, who will articulate our concerns. I thank you for your attention.

**Dr Judith Hamilton:** I am very pleased to be able to make this presentation to you today.

Psychiatrists are very familiar with the feelings, thoughts and behaviours of patients who have suffered many forms of abuse, including sexual abuse. Indeed, psychiatrists as a profession have led the way in discovering and documenting the effects of sexual abuse on patients.

There is much in Bill 100, both in content and tone, with which we strongly agree. We would like to confine our comments today to the proposal for mandatory reporting.

Mandatory reporting is especially important to us

because, among physicians, we psychiatrists are the most likely to hear from patients of episodes of sexual contact they have experienced with a physician or any other health care professional. For our work with patients to be effective, we encourage, even require, them to tell us, sometimes over long periods of time, everything they can about themselves as openly and truthfully as possible. In this sense, we induce them to disclose confidential information. A law that would then compel us to take advantage of their illness and trust and to break confidentiality would be extraordinary.

The issue of mandatory reporting is also important to us because psychiatrists are consulted by other physicians or health care professionals who may have concerns about their own professional behaviour or who have a psychiatric illness that may have included an episode of sexual contact with a patient.

An important part of the training and professionalism of a psychiatrist is the proper exercise of judgement in the clinical situation. We rightly are held accountable for these decisions, which must be made with the overall clinical picture in mind, guided by the duty to preserve and protect the patient. Accountability would also apply to any decision a psychiatrist would make with respect to mandatory reporting, either to report or not to report.

**Sexual abuse:** The section on psychiatry, the Ontario Psychiatric Association and the Toronto Psychoanalytic Society completely agree with the prohibition against sexual contact between a psychiatrist and his or her patient during psychiatric treatments of all kinds. It is always unethical and constitutes professional misconduct. This position is consistent with the position of the Canadian Psychiatric Association.

**Beneficial and manageable effects of mandatory reporting:** We support mandatory reporting of sexual abuse for the categories identified as transgression and violation. For the category of sexual impropriety, we agree with the Ontario Medical Association and the coalition of professional associations that this is much better dealt with by the professional intervention and education model implied by the duty to intervene.

For most psychiatric patients, mandatory reporting will have beneficial or at least manageable effects. For example, when patients present to psychiatrists because of psychiatric symptoms arising from experiences of sexual abuse from a health care professional, there is usually no problem with the psychiatrist's reporting the episode to the appropriate college.

For the patient for whom psychotherapy is indicated, there can be a problem of timing and about who will report. For this kind of patient, the psychiatrist's obligation with respect to the goals of treatment is to work with the patient to enable the patient to report the episode.

However, for these patients who present with symptoms arising from sexual abuse, the central issue is clear, and its clarification and the discussion of actions to be taken and by whom forms a natural part of the consultation. These patients may be relieved that the psychiatrist is obliged by mandatory reporting to report the episode and reassured by the anonymity offered.



When patients describe, during the course of an extended psychotherapeutic or psychoanalytic treatment, a recalled episode of sexual contact with a health care professional, complicating considerations arise. For example, the episode may have occurred any time from the recent past to the distant past and it may consist in the patient's recollection of any variant of behaviour, from a nuance of sexuality to an overt sexual act. Pursuing the details of the experience to satisfy the mandatory reporting requirement, imposing a certain view of the experience on the patient, and reporting to an unknown person outside the treatment all represent significant alterations in the therapeutic process and contract.

This being said, for many patients in psychotherapy and psychoanalysis, the discussion about an experience of sexual contact and the reporting by either the psychiatrist or the patient can probably take place without too great a disruption of the treatment. Because of the importance of the development of trust for a successful psychotherapy, it would be unacceptable for a psychiatrist to report the experience without first telling the patient.

#### 1640

**Harmful effects of mandatory reporting:** There are several groups of psychiatric patients for whom mandatory reporting will be harmful. Therefore, the needs of some of these patients require flexibility in the form of exemptions in the requirement for mandatory reporting.

There will be patients who will be very alarmed and frightened by the prospect of reporting to a regulatory college an experience of sexual contact, even if the psychiatrist reports and even if they are assured of anonymity. Some of these patients will not want such an episode reported, at least at the time when they first raise it. Even faced with mandatory reporting, some of these patients will refuse a psychiatrist permission to report.

If the issue is forced by a legal requirement that the psychiatrist report, these patients may experience this as a traumatizing invasion into their already injured lives of society's demands, a victimization by the very agencies that are trying to protect them. They may feel frightened by the threat of exposure. They may even feel they have been tricked by the psychiatrist into revealing the episode. Already vulnerable, abused patients will feel revictimized by yet another professional: the one who reports their experience to the college against their will.

Therapists in other settings—for example, feminist therapists treating victims of rape and other forms of sexual abuse—are adamant that in their work they would never force a client to report her experience to the authorities, nor would they report it against her will. They know, as we do, that such forced reporting would destroy the client's trust in the therapist, it would not be serving the client's needs at the time, it would be disempowering in the extreme and it would be completely anti-therapeutic.

The offer of anonymity to these patients will not reassure them. Many are psychiatric patients for the very reason that they have been used since childhood to satisfy the needs of other people, usually parents or other people in authority. They know that they are traceable through the name of the reporting psychiatrist. They know that

this report may come back to them through the psychiatrist as information from the college that another report has been received, and as an implied or overt request: Would they now be willing to participate in a complaints process? In spite of the fact that they have declared that they do not want this, they will feel pressured by the college and society at large to get involved in the complaints process.

Then the next months and years of their therapy and lives will be inexorably caught up in this process, either in their minds, if they still refuse to participate, or in reality, if they agree. Their personal developmental needs will be lost from the therapy. Their therapy will be lengthened, and the costs increased. They may well need medication to get through this, and their suffering will be greatly increased. With such a breach of trust in the relationship with the treating psychiatrist, these patients may break off the treatment altogether.

Other patients may feel extremely offended by the threat to their privacy that mandatory reporting poses. These patients, who consider themselves to be personally strong and in control of their own lives, may become enraged at the psychiatrist who insists on their reporting, or reporting for them, what they consider to be their own experience. Feeling cornered and infantilized, these patients may also break off the treatment.

Finally, there is another group of patients who require some flexibility in mandatory reporting; that is, potential patients who know about the requirement for reporting and do not want an episode reported. These patients either will not come to a psychiatrist for treatment of any psychiatric problem or will try to withhold information about such an experience from psychotherapy treatment. For example, they might plan to withhold a name.

The illness and suffering that would result from potential patients not coming at all is painful even to think about, and as anyone in ordinary life who is trying to hold on to a highly emotional secret knows, the secret gradually consumes the whole of one's consciousness. Not only would such a patient's psychotherapy become increasingly blocked and ineffective, but the effects of the experience itself would not be discovered and mastered, including the patient's developing the strength to report.

Patients not coming for consultation and treatment is an alarming concern when the potential patient is a health care professional either who is concerned about the appropriateness of his or her own professional behaviour or whose history includes an episode of sexual contact with a patient at any time in the near or distant past. Such a person will not likely consult with a psychiatrist if they expect to be automatically reported. What was an improper remark or gesture, or even only a fantasy of increased involvement with a client or patient, may, if left undiscussed, go on to become a serious boundary or sexual violation. If a health care professional for whom sexual contact with a patient or client was either the regretted consequence of psychiatric illness or an unacknowledged transgression of professional conduct goes untreated or uninfluenced, he or she could pose a significant risk to other patients.

Psychiatrists are not willing to act as shields or hide-



aways for abusing professionals, so an exemption allowing non-reporting would always rest on a clinical judgement taking into consideration the risk to other patients. Any decision with respect to reporting would be subject to standards of professional accountability. Non-reporting by the treating psychiatrist would not stand in the way of a patient-initiated complaint about the professional. Non-reporting would not stand in the way of a full investigation of any complaint brought forward by another individual. In the event that the professional does present for discipline, the college should judge the case on its merits, not on whether or not the professional is in treatment.

Proposed amendment: Therefore, because there are several groups of patients to whom absolute mandatory reporting will cause harm or prevent their getting the treatment they need, the section on psychiatry urges the government to adopt the following amendment to Bill 100:

"Psychiatrists are allowed a limited exemption from the mandatory reporting requirement in the following circumstances:

"(a) when a patient in psychiatric treatment refuses to give permission for reporting; and

"(b) when the psychiatrist considers that more harm than good will come from the report."

**Mrs Yvonne O'Neill (Ottawa-Rideau):** This is a very important brief because of the key role you're going to play and do play at the present time in the treatment of the situations we're trying to eradicate or at least bring into a more positive vein.

You said one thing that struck me, and I would like you to say a little bit more about it because I think those of us who are not part of your profession don't fully appreciate this. You said that it would be very detrimental to the treatment you provide to impose a view. I wonder if you could say a little bit more about that, because I think the whole of Bill 100, as you would have to apply it, would revolve around imposing a view: a view that this had to go forward in the manner in which the bill states it must. So I'd like you to say a little bit more, if you want to use an example, of how that would—because you have stated throughout the brief, and I tend to agree, that this bill could be harmful to your practice.

1650

**Dr Hamilton:** Certainly for many patients, if they come with symptoms arising from an actual experience of abuse, they come in a state of distress and it's very clear to us how they experienced the whole situation, and they are prepared at that point to get interested in the process of reporting. When you think about the patient who's in a prolonged psychotherapy experience, when such an example comes to their mind, they may not experience it with distress. As I said, there may have been something incidental to them that happened in the past. There may have been a vague experience. It may be a barely remembered experience. They may not initially think of it as something bad that happened to them.

For the psychiatrist to suddenly interrupt the treatment and practically sit the patient upright and say, "Now, this

may involve an experience of sexual abuse and I want us to stop the therapy at this point and investigate this, because, you know, if we agree that it was sexual abuse, we have to report to a college," this becomes a whole change or alteration in the course of this patient's therapy.

That's not to say that this experience would not be brought up at a later time or in another context or explored further even, at the time, but once the psychiatrist gets telling the patient what their experience was, it changes the whole nature of the treatment and it no longer belongs to the patient but becomes society working through the psychiatrist to tell the patient what they've been through.

To us, this is breaching one of the very tenets of psychotherapy and psychoanalysis, that it's the patient's life and their experiences that we're trying to help them evolve and work through, not imposing our own views on them.

**The Chair:** Can I just note for everyone that there's going to be a bell at some point in the next five minutes, so in order to allow our next witness the full 15 minutes, we'll just complete questioning and then break and we'll come back with Ms Stasha Novak once we have voted, which should be somewhere between 5:05 and 5:10.

**Mr Jim Wilson:** I think you've given us a very thoughtful presentation. As usual, as legislators we're kind of used to being in a quandary, and we're in a quandary with respect to mandatory reporting.

I'm interested in the second part of your suggested amendment, which would introduce sort of a harm test. Given what you were just talking about with respect to the interruption of therapy to actually have to discuss this process, where would the harm test come in? I'd assume you would hear out the patient. If we don't make adjustments to other parts of the act, though, the moment you hear about sexual abuse is when the reporting process is supposed to begin. I wanted to just ask you when that test would apply.

Secondly, I think some survivors or other very concerned people might get suspicious that for psychiatrists, because they're part of the medical profession, this might be a clause to enable them to get away from the whole issue of having to report colleagues or other health care practitioners. I want you to address that, because I'm sure it will come up in the rest of the hearings.

**Dr Conlon:** I think you're absolutely right in the sense of the harm. It really is a clinical decision that's made in therapy when you in fact would deem that to go through the reporting mechanism at that point in time would cause more harm to the actual patient who is in treatment than potential benefit. That doesn't at any stage preclude a reporting later on if it was felt that, if you like, the balance changed somewhat through the course of therapy. In fact, that would be what we would hope, that throughout therapy there would come a better time when the patient may be able to deal with the reporting of the incident. It's certainly one of the goals of therapy to arrive at that point; in other words, to empower the patient with the ability to do that.

The second part, and I think it's a very important point, is that in no way do we want to obviate the profession or psychiatrists from the responsibility this decision brings about. In other words, you would be held professionally accountable at all times for that decision. If you made a decision of non-reporting, let's say, at that point in time but subsequently it came to light that abuse occurred and there was an investigation, you would have to justify, as a professional, why you didn't report. You would clearly have to have documented evidence within the clinical notes, as we do for many kinds of decisions, and would be held professionally accountable by your peers for that decision. I think if you made an inappropriate decision, for whatever sorts of reasons, you would be held accountable and would be subject to discipline.

**Dr Hamilton:** We think that should even be included in the bill perhaps, like an extra accountability clause related to mandatory reporting.

**Mrs Karen Haslam (Perth):** On page 3 you mentioned something about, "Patients may be relieved that the psychiatrist is obliged by mandatory reporting to report the episode and reassured by the anonymity offered." I wanted you to expand a little bit about that because I'd rather err on the side of the victim in this legislation. I'd rather this legislation looked at that aspect. In the last few days we've heard from a lot of professionals and I just have a feeling that the victims are sometimes being lost in all of this discussion. Would you just expand a little bit about how they'd feel "relieved that the psychiatrist is obliged by mandatory reporting to report"?

**Dr Hamilton:** Some victims in this situation feel, I suppose as everybody does, that relating to a regulatory college is an anxiety-provoking experience. Some are very frightened about what might happen to them as a result of that, so they feel anxiety, they feel guilt about coming forward, they feel fear. They see other victims on television—I guess we've all just seen that recently—what happens to victims who come forward in complaints processes. So many people would rather not get caught up in that whole experience.

The idea to some of these people that someone else will do the reporting for them and that there is the promise of anonymity can make them feel easier about reporting, can give them the idea that they may not get caught up in the process if they don't want to. That is enough to help some report at that point in time, or allow for reporting.

What we're concerned about is those people who are in a way more ill than that, who will be more frightened than that, who may develop even a paranoid response to the idea of information from their therapy going forward to a regulatory college.

**Mrs Haslam:** Can I switch very quickly and very briefly? There's a recess for five minutes.

**The Chair:** It's a recess? Okay, if we just finish this one question.

**Mrs Haslam:** We should be okay. I'd like to switch now to your last page where you say "when a patient in psychiatric treatment refuses to give permission for reporting." What about the doctors or an abuser who

comes in? I think Mr Wilson has mentioned that, that we don't want to see this as a way to get out of punishment at the college by saying, "Okay, fine, I'll go and see a psychiatrist," because I think our fear is that then will have an effect on whether that's reported or not, and we feel it's important that it is reported. I'm concerned—maybe it's just the comment—that when you have a patient in who is an abuser and doesn't give permission, then it's never reported.

**Dr Hamilton:** The point we'd like to keep making is that we're not saying that we would not report because a person refuses. That's why we've inserted the idea of more harm than good. We're trying to use a general idea of harm too. We would like to work on the understanding that we would accept mandatory reporting but that there would be the occasion when we would feel that it would be more harm than good to report. If an abuser presented to us for treatment, we would ordinarily feel that we would like to report. We know that we can always report. Also, if a person presents for treatment, it's always possible for someone else to report them. We would never stand in the way of that.

**The Chair:** We are going to have to stop there. It's a little confusing as to whether we're going to have to go up shortly to a vote, but I think I will just have to at this point say thank you very much for your submission and for the answers to the questions.

1700

STASHA NOVAK

**The Chair:** I will then call Ms Stasha Novak to come forward. Is Ms Novak here? I hope we'll not have any problem with our time, but if we do, we will ensure, after we have returned, that you have the full time that is allocated to you. Welcome to the committee. Just so we can hear you, could you just speak into the mike. Please go ahead.

**Ms Stasha Novak:** My name is Stasha Novak. I cannot speak very well because the dentist who assaulted me also didn't do the dentistry very well. It's not a laughing matter, but it's okay.

I don't know everything that is in Bill 100, but sometimes when we are in a professional's office we don't know exactly what is professional misconduct and what is sexual misconduct, but when it happens in an office most likely the professional services are compromised as well. In my case, they certainly were.

I wrote something, so I have to rely on that as well. I will start with that.

Seven years ago, I was gainfully employed, my credit rating was A, I was a part-time student at the University of Toronto, I had an apartment, I had good health and I had my teeth. The teeth are very, very private. We talk about any subject today except—I don't know.

In a short time I lost everything. I wasn't involved with dealings of organized crime. I was the recipient of professional services by an incompetent dentist, a lawyer, a psychiatrist, a doctor, whose code of ethics and professional standards are monitored by their respective self-governing bodies.

All I wanted in 1980 was to have my teeth done, and



I wanted to continue with my life as normally as I possibly could. Instead, my dental case and my health have been suspended in limbo by the Royal College of Dental Surgeons of Ontario and my two former dentists. Since 1988, I've been held hostage to conditions created by the dentistry. My bank account has been depleted by over 100 dental appointments. In the process, I lost all dignity. The dentist, who was not qualified, did dental work on me. He sexually harassed me, he assaulted me, he refused to forward my dental X-rays and material used in my work to another practitioner for reconstructive dentistry and he misquoted dental fees to me. He said he has good lawyers and they're going to get me.

At the first hearing when I went for dental misconduct, I felt intimidated and I didn't tell the committee. Subsequently, the lawyer sent me to a psychiatrist to make an impact statement on how the dentistry affected me. I was so relieved, because I was able to unload what I was carrying so heavily. Unfortunately, the psychiatrist forgot to put it in his report. In fact, I believe the psychiatrist's letter was ordered to be written in such a manner that I could be discredited any time when it would be convenient.

I don't know how comfortable you are as a man, as a woman, because it's not a women's issue; I believe it's a human issue. I would like to know, how would you like to see your wife, your daughter, your husband, your grandmother or anybody go to a dentist and have psychosexual development mentioned in his or her psychiatric report?

The psychiatrist was supposed to write a report how the dentistry affected me mentally. Instead, I will read you a few comments. This psychiatric assessment was also sent to the Law Society of Upper Canada when I filed a complaint regarding my lawyer. In spite of overwhelming medical and dental evidence, only the psychiatrist's statement has been sent to liability insurance. Since everybody knows everything about me, I might as well tell you as well:

"She had at least one long-term relationship with a man which ended five years ago. It was very difficult for me to obtain detailed information on her psychosexual development and other peer relationships. However, I was left with the impression of a rather constrained, precise, perhaps somehow obsessional woman who devoted herself to work and had few other activities to occupy her." I don't agree with this statement and my friends don't recognize me either.

"She attended school until grade 12. Unfortunately, in 1956 her father died and she left school and she started work, as noted above.

"She immigrated to Canada alone and hopeful for a new future. She proved to be resourceful working as a domestic." I escaped one communist country. I didn't go to the passport office. Yes, I did work as a domestic, 12 hours after I arrived in Canada. I'm very proud of it.

"She worked for approximately 19 years. It is of note that she worked steadily but was never promoted." There is no mention of assault by the dentist.

Another statement I would like to add is, "She was

directly involved in witnessing violent and brutal murder...by the Nazis and was terrorized by seeing members of her family taken to the concentration camps. Her father was taken at gunpoint," etc. This psychiatrist feels right to retraumatize my family and my childhood trauma, as if reporting war trauma would give him credibility for the accuracy of the rest of his report.

The psychiatrist used questionable Freudian theory, analysing my childhood years instead of looking at my face today, disfigured because of this dental work. My facial bones are sinking. My loss of bone is pronounced and it's worsening by time. My face will be disfigured until I die. I lost six years of my life. I live in perpetual hell and I'm not out yet. My facial pain and strain and infection in my mouth of several years in duration, affecting my entire body and my immune system, doesn't call for digging into my childhood events some 50 years ago on another continent. Psychiatrist, don't trivialize my pain.

He assaulted me the moment I walked through the door because I brought to him an estimate and I asked him if he could do the dentistry. He wasn't qualified. In one moment, it was professional misconduct and sexual misconduct. When he grabbed me and he assaulted me, I didn't go back any more. I didn't know how to deal with it. I had never been in this situation. I don't walk around provocatively, and even if I would, his wife was his dental assistant.

Who am I supposed to talk to? I live by myself. It's not that seven million people don't live in Toronto; it's just I didn't know how to deal with it.

Finally, I filed a complaint with the college of dental surgeons. I believe they had already my psychiatric assessment, because the liability insurance is in the same building and perhaps there is a file; I don't know. So I walk in and it was a total charade. I got a lawyer who was very, very conscientious. I can name him; I don't know if you'll allow me to. He believed me, my friends believed me, everybody believed me, and it was just a charade. I signed the statement and I sent it in the mail. He denied by mail and said I am a liar and have a psychological problem.

**1710**

Finally, I went to the justice of the peace with several letters. It is too late to go to the court to be charged, but the two justices of the peace believed me. In fact, they suspected that he has done it to somebody else as well.

I'm sorry for my clumsy presentation. Obviously, it's very difficult for me. I hope you understand this.

**The Chair:** Thank you very much for your submission and also for the various documents which you have attached to it. We appreciate that it's not an easy submission to make, but thank you very much for coming before the committee today.

MED-AWARE PUBLICATIONS.  
PATIENT ADVOCACY ISSUES

**The Chair:** I then call upon Ms Elizabeth Rankin. Miss Rankin, we may have to suddenly leave you, but I assure you we will provide all of the time, and until the bells go we're in your hands, so please go ahead.



**Ms Elizabeth Rankin:** You've introduced me as Elizabeth Rankin. I am here as a survivor of medical abuse and an advocate in terms of trying to do patient advocacy work on various health care issues.

**The Chair:** Sorry. Just to interrupt for a moment, we do have a copy of your submission.

**Ms Rankin:** I really wanted to deal with some of the provisions that I see are issues that have not yet been covered sufficiently. When I hear some of the presenters and I see and hear some of your questions, I see that there's got to be a little more refinement in the amendments to Bill 100 in order to seek further clarification. I'm hoping that my submission in greater detail will offer some use to you in that regard.

In regard to the provisions where "appropriate standards of practice are developed and maintained," that "individuals have access to services provided by the health professions of their choice" and that "they are treated with sensitivity and respect in their dealings with health professionals," I would like to assist you in making the provisions more workable. I will highlight some of the points for this presentation:

(1) There is a need for a broader definition of what constitutes sexual abuse that refers to and considers the lack of research on women's health problems, which I believe is the basis for exploitation of women within the currently defined medical standards of practice. Primarily, my brief that is submitted to you and the presentation that I will be making concern medical practice as opposed to the other regulated health professionals.

(2) Male gender is the variable for control of women's bodies, which spawns and nurtures abuse in health care.

(3) There must be recognition for utilizing survivors of abuse as the critical proponents in the movement needed to change the standards for both medical and health care practice, and I differentiate those because they really are two.

(4) I think it's very important that we consider moving the hearing process from the colleges to an independent panel using a civil procedure.

The problems within the current provisions and the current amendments in regard to the "appropriate standards of practice": I feel we need to have a coalition established to develop a model for health care practice which would be comprised of an equal number of survivors and professionals to review, define, implement, monitor and evaluate which current standards of practice are, can be or should be considered outmoded, unsafe; are said to be demeaning, seductive or exploitative; are or could be said to be a physical, sexual or emotional assault to patients. The coalition would assist the RHPs to reform their standards for practice and provide remedies where it was felt sexual abuse and its variant, sexual exploitation, are actually abusive or could be perceived to be abusive.

Survivors have a critical role in helping all professionals learn more about how abusive professionals wield their power and engage patients in abusive forms of practice. Therefore, they must be involved with the development of any standards for practice. Standards that

are unacceptable but have been tolerated by the public and are presently considered acceptable standards of practice by members must be now re-evaluated.

Why change standard practice? There are numerous questionable medical standard practices that are known to be unsafe or unscientific, demeaning, sexual, emotionally threatening, unnecessary or exploitative, and these include but are not defined as or limited to genital mutilation. The medical community does not describe the activity or practice of routine episiotomy, which is only one area that I will describe, as a form of genital mutilation, but it is arguably nothing short of such a trauma. Episiotomy is a surgical procedure that cuts into the perineum and vagina of the woman as she is giving birth vaginally and often creates sexual and bladder dysfunction, not to mention the unnecessary pain that is inflicted on patients. The practice is rarely used in other countries or where the mother is attended to by midwives, but it has become standard practice in cases of obstetrics in North America.

The committee must understand that standard practice has encouraged sexual abuse. This legislation must demand the review of many such medical standard practices for women so they are no longer routinely allowed to continue just because this is the way the doctor has learned to practise.

Sexual abuse is a concept that is broad, and this legislation must be sufficiently broad in its scope to assist those who are charged with the responsibility of making change as well as those who represent the public.

I have concerns about the MOH proposing to delete subsections 1(4) and 85.1(2) regarding "Subject to the approval of the Lieutenant Governor in Council and with prior review by the minister, the council may make regulations clarifying or extending what constitutes sexual abuse of a patient by a member." Unless this subsection is left in, I believe there is little room for regulations to be clarified and extended in what constitutes sexual abuse of a patient by a member, unless I have misread or misunderstood that particular amendment.

It would be a good idea to have a reference made to such type of practice in the legislation that includes procedures that could be considered sexually abusive. A point of reference will allow patients, advocates and member professionals to be observant of how a certain practice is or might be harmful to patients and how incompetence or liability could be contested.

There is a lack of research for women. There is as little as 3% of total research dollars spent on women's health problems in Canada. The drugs prescribed for women are based on the 70-kilogram man; they are not researched as to their effectiveness for women. This is exploitive and unsafe practice. Women are essentially the guinea pigs when they are subjected to the drugs said to be tested as safe for men. For example, estrogens are promoted for women to reduce the chance of heart disease. We do not know for certain that the estrogens that are promoted for women do in fact reduce the risk of heart disease, because there hasn't been sufficient research. Perhaps there needs to be a health risk warning on the package of drugs for women so that the risk labels draw recognition to the fact that the medical community

does not always know with any degree of certainty that the drug is safe. It is this type of controversy that must be settled to reduce the incidence of problems which have resulted from cases like the Dalkon shield, Meme breast implants, DES, thalidomide, and the list goes on.

I believe we need strict research guidelines that will prevent sexual exploitation of women in the area of drug use and surgical interventions. This government, through Bill 100, can reduce this discrimination and exploitative practice and offer all women an opportunity to be better cared for by insisting that a proposed coalition be established which confronts the issues facing women in health care. Women are entitled to have women define for women which areas of research deserve attention.

Sexual abuse by professionals involves far more than sexual touching, remarks and intercourse; it involves the entire arena of exploitation that is only briefly alluded to in this submission.

For instance, we do not research problems that plague women and might be considered being sexually induced problems. Problems that are sexually induced and subconsciously repressed need attention. We need to have studies that look at women who have been sexually assaulted and see the relationship to uncovering that incest or other sexual deviant assaults to the psyche have resulted in such diagnosis as endometriosis, infertility, fibrocystic breast disease.

The amount of money that has been spent to try and medically or surgically correct these conditions to no avail could have been better spent if research had been done to uncover how closely the abuse that affects women controls their hormonal response. Often pain is the physical symptom in a sexual organ to signal to them that the abuse has happened. Patients are often unaware this is the case until they get counselling or are beginning to talk about their suppressed emotions.

There is not the value attached to this kind of research. It's not exciting enough for pharmaceutical companies and so this kind of evidence is not getting to doctors and women are not getting proper treatment.

I believe this is a form of exploitative practice, because women instead are given the old, unhelpful standard practice of prescribed mood elevators or they are given treatments which focus on the organ, usually a drug to suppress some hormonal response—

**The Chair:** Ms Rankin, I apologize. The bell is ringing and we have to go to the House for a vote. We will be back shortly, probably in about 10 minutes, so I would adjourn the committee now and we will try to begin again in about 15 minutes.

*The committee recessed from 1722 to 1803.*

**The Chair:** We begin our afternoon, now evening, session and Ms Rankin, again I apologize that we had to cut you off, but I think there was some five minutes left in your time, so if you would please continue, just so you understand, in the record of the committee it will simply show there was a brief recess, but your testimony will follow right along, so anyone looking at it will see it in its entirety as one presentation.

**Ms Rankin:** Thank you very much. I'd like to begin

where I left off, which was talking about sexually induced problems and the need for research. I think I left off saying there is not the value attached to this kind of research for women, because it's not very exciting for pharmaceutical companies, and they largely are the bodies organizations have depended on, on receiving their funding, so women are not getting proper treatment.

I believe this is a form of exploitative practice, because women instead are being given the old standard practice of being prescribed mood elevators or they are given treatments which focus on the organ, usually a drug to suppress some hormonal response or surgically removing it, which never solves the underlying problem.

Now I'd like to move along to another issue that I think is extremely important. The use of male physicians examining female patients' most intimate body parts where the female has not been given the choice of having a female examiner is an exploitative practice. Women have been seduced into tolerating this type of examination process only because it has become an unquestionable or unchallenged standard practice. I suggest to you that this type of control over women's bodies and the fact that women have had little access to having female practitioners has spawned and nurtured the fraternity that has encouraged sexual abuse in health care.

Individuals must have access to services provided by health professionals of their choice, and while it is allowed in the provisions, it's going to have to be something that the government will have to wrestle with in terms of allowing, over time, quotas or some means of getting the appropriate number of practitioners to meet the demands for females.

For instance, if a female wishes to see a urologist, it's almost virtually impossible for her to get a female urologist. As far as I know there are about two or three of them in Canada. I tried contacting both the College of Physicians and Surgeons and the Royal College of Physicians and Surgeons and neither could give me a gender breakdown, so I'm dealing with an old piece of information. I would suggest that given this awareness, this government must begin to restrict the number of openings for male urologists as specialists until the quota for this specialty is equalized by the demand for female urologists. Similar quotas should apply to obstetrics and gynaecology.

Recognizing that sexual abuse is a gender-related problem, this government must ensure that all women have female practitioners if this is their choice. Harassment and exploitation at the hands of professionals create devastation for a lifetime. It is a stress-induced sentence that is incalculable in its cost, both financially and socially, both to the victims, their families and that of the perpetrator and his family.

I want to talk to you about choice of health professional in terms of how medicare is set up to fund and pay for health services. It seems that unless they are deemed to be of a medical nature, currently, it's very difficult for nurses, psychologists, massage therapists, naturopaths and others who are external to medicine and who are often excluded from helping consumers get a choice of paid service. This government should ensure



that within the RHPA, as in the provisions that are set out, more services of those professionals who make up the RHPAs will be paid so that consumers do have paid accessibility to their choice of service provider.

Many of the alternative health care professionals are female, who with little integration of additional training can assist women to maintain a high level of wellness and health care throughout the continuum of the life cycle and who can assist this ministry to make the best use of existing health professional services.

I want to go on to legal reform. Underlying all fairness in the system will be reform in the hearing process. The process, which is now clearly quasi-criminal, must be moved to be more of a civil proceeding.

Hearings that are of a sexual nature in particular should be removed from the college and a separate tribunal should be set up to hear cases of sexual abuse, where the tribunal members are both knowledgeable about the dynamics of a sexual abuse relationship and have no attachment or professional affiliation to the member. Preferably, they are chaired by a legal member who is trained in civil procedure.

The college argues it already tries cases in a civil context. Were that true, the following would be implemented: All complainants would be represented by independent legal counsel and there would be no longer the role of a prosecutor, a strictly criminal procedural tactic. Remember, complainants are not charging professionals criminally. They are lodging a complaint as part of the process.

All defendants who had previous convictions or suspensions and were on the record for sexual abuse matters would have this evidence disclosed by the complainant's lawyer, as in any civil proceeding. Presently, this evidence is not permitted under the current hearing process, as it is said to be prejudicial, which is also a criminal tactic.

#### 1810

**Recommendations:** That all evidence be disclosed that is supporting any sexual behaviour, past or present, as in any civil proceeding; that all complainants receive paid legal representation by the college; that the role of prosecutor become redundant; that the Canadian Medical Protective Association costs not be underwritten by this government.

The medical profession is the only professional group that has its liability insurance underwritten. Aside from being the wealthiest professional group, which could perhaps afford this insurance coverage, it's discriminatory in that it doesn't allow for any other professional group to be covered. I think the \$37 million that goes to cover this questionable funding could be put to better use in the way of either compensating victims or setting up tribunals, or in some other way, but I certainly don't think it should be aiding and abetting bad doctors.

All complainants whose evidence was considered valid and who wished to testify should be given the right to a hearing and not asked to withdraw their complaint to allow for plea bargaining, which is another criminal tactic, and it's well suited to both the college and the

defendant member. It would be in the college's interest, particularly in light of proposed compensation, for charges to be dropped, because if you can get one guilty finding and get the doctor's licence revoked, which it may well want, it frees the college of the financial obligations to any other witnesses who come forward, because if they don't get a guilty finding to their allegations, their case is simply withdrawn.

It also assists the professional to get one guilty finding, because to date it's been very obvious that the courts seem to overturn many of the decisions that the college has for revoking a doctor's licence.

Before I end my presentation, I'm going to just generally make a comment. I really feel privileged to be able to come here today. I also feel privileged because I've been involved with the consultation process along the way. I never got involved. I'm not a political person and I've never been involved in politics, but I really think this has been a wonderful way of feeling like I'm getting involved to do something that I think is important.

A comment that I don't have in my brief, because I had to make it fairly brief, was that I think that this government must support mandatory reporting on all levels. After listening to a very articulate presentation by two psychiatrists, and I'm sympathetic on the one hand to what they have to say, I really am not sure whether psychiatrists and doctors just don't feel, and perhaps other professionals, that mandatory reporting should be able to be done on a reporting basis as well as lodging a formal complaint. They should really see the difference.

A patient might not want to lodge a formal complaint, but they jolly well might want to report the doctor. My fear for the patients they're talking about is that once they get to a level where they're feeling a little bit better and they find that some of their friends or somebody else has been abused by the same psychiatrist, they're going to be in an awful position when the patient says to them, "But why, when you knew and I wasn't in a position to really make that decision, did you not at least report him?" I really can't see, from anything I've studied or thought about, why mandatory reporting should never exist.

To conclude, I only want to say that I think it is important that this government balance a patient's right to justice and that they are not lost in the process. I get the feeling that the government is working very hard in this regard and I hope that this is the way it will be. I want to thank you. I appreciate your interest in having me make this presentation and submit my brief.

**The Chair:** Thank you very much for the written brief. While you weren't able to read everything, we have it so that we'll be able to look at that. We have time, just briefly, for questions.

**Ms Haeck:** Actually, Ms Rankin, you have answered, at least to some degree, my concern, which is that the whole duty to report be there as part of the practice, that if someone knows about it, they should be reporting it.

The OMA is putting forward something called the "duty to intervene," and there are several parts to it. One of them I think is something that you should know exists.



It puts forward the idea that it might be incumbent upon the professional, hearing from you, particularly in the case where there is a sexual impropriety, words that you may feel somewhat uncomfortable with to go to speak to the perpetrator. As I say, there are several levels to this, but that's one of the ideas being put forward. As a survivor, how do you feel about that kind of action?

**Ms Rankin:** Is that to intervene and replace the actual reporting to the college? In other words, we'll do this first?

**Ms Haeck:** That is being suggested as an alternative.

**Ms Rankin:** I don't think it should be an alternative. I think it's quite okay and probably should happen if a doctor or another professional recognizes something's going on. I don't think it should be a substitute, because it's the old boys' club that's always worked and it sounds like it's still working.

**The Chair:** Mr Rankin, thank you very much again for coming before the committee. I apologize for the need to split your presentation into two.

**Ms Rankin:** That's okay. Thank you.

SHARON DANLEY

**The Chair:** I call on our next witness, Ms Sharon Danley, if you would be good enough to come forward. I might just say to members of the committee that Ms Danley has brought with her a video which we will be seeing at a later date. She is going to make her submission to us and be prepared to answer any questions. She has also left with us some attachments. Perhaps, Ms Danley, you would just introduce yourself and also your colleague or friend who is with you.

**Ms Sharon Danley:** I'm Sharon Danley and I'm with the Coalition for Medical and Legal Reform. To my immediate left is Velma Demerson, also a member of that particular coalition.

Ladies and gentlemen, I'd like to thank you for this opportunity to present a firsthand account as a survivor and my colleagues' grave concerns over Bill 100. My presentation was to be in the form of a video made back in March. However, we'll let that go for another time and I'll be happy to attend to answer any questions at that point.

My written brief also includes my victim impact statement, as given last Wednesday at the sentencing portion of my hearing. It gives an honest, graphic overview of some of the trauma and violations incurred not only from the offending doctor's original assault but as well from the reliving of that assault during the hearing and the multiple violations I have incurred throughout the whole process of discerning justice.

To give you just a quick overview of why I went to the college, 16 years ago I took my two-year-old critically ill son to see his doctor as he was in severe cardiac distress and my fear for his life was my driving force. Dr Cameron quickly examined him and consistently diminished my concerns for my son's life. I picked my child up and then, to my horror, I was sexually assaulted by this doctor with this dying child in my arms. It bears repeating.

Hugh Cameron lunged at me, forcing his lips against

mine, putting his tongue deep into my mouth. His eyes were fiercely glazed and he was panting. He vigorously manhandled my torso, particularly my hips and my breasts. He then put one hand inside my blouse and pawed at my one breast while I was holding my sick baby against the other.

1820

Three days after the showing of this particular tape that I was going to show today, I was told to appear in front of the tribunal, with less than 24 hours' notice, to reopen the case with what proved to be vindictive, false testimony from an ex-intimate which was blatantly irresponsibly investigated. I will override my keen temptation to disclose what incredible, irreparable damage that did to me, except to say that it cost \$32,000 and two valuable days of court time. And the college dares to complain about expense and overload.

On June 25, Hugh Cameron was found guilty of sexual impropriety. It was in fact a gross crime of sexual aggression and assault. Calling it improper is an insult, diminishes my pain, the violation to my son and the seriousness of my assault. Even though I was violated with my dying child in my arms after Cameron completely diminished my concerns because he was clouded by his lust for a vulnerable, scared mother, the college didn't see fit to find him guilty of professional misconduct arising from his medical negligence. If this wasn't unprofessional, in fact grossly negligent, then what in the name of justice is?

Examples of our concerns over definitions of sexual violations—by the way, Hugh Cameron was employed for five months by East General hospital after his guilty finding. They gave the coalition legal excuses but not moral reasons for this outrage. Pretty irresponsible, isn't it?

When my psychiatric and sexual history were subpoenaed against my vehement protests and I informed the players that I found numerous factual inaccuracies, distortions and minimizations, I was completely ignored. I didn't have the necessary legal counsel to help me fight for my emotional life in this and other areas of concern. The question begs asking, why wasn't a psychiatric assessment done on the offending doctor, rather than me, as part of the process?

Examples of not having full-party standing—while on the subject of psychiatric and psychological competence, many of us find it astounding this particular community continues to demonstrate how dysfunctional it is in the areas of sexual assault, revictimization and reliving incest memories. They are dangerous to women's sexual healthiness and wellbeing.

Example: One of my practitioners suggested that I should look into my past—because, after all, I was an incest victim—rather than help me develop coping skills to deal with family, police and the children's aid for not taking responsible action in responding to and making amends for my daughter's sexual violation.

Another practitioner, while attending me through the proceedings where my past was being defiled and thrown in my face, took me through incest memories against my

stated will as a form of therapy. It took me a week to get out of my depression and out my bed. Fortunately, I terminated her. Other victims don't possess this strength due to their therapy. Scary, isn't it?

Yet this is the very community that claims to know how to categorize and therapize victims and also claims to know how to rehabilitate perpetrators. My medical doctor dropped me because I wouldn't get therapy or take psychiatric drugs to numb me during this hearing. Treat the reaction, not the action. The fact that I haven't seen a therapist or even taken so much as an aspirin in almost a year and have managed to survive what I have speaks volumes for my own skilled modalities of healing. In other words, therapy of choice must absolutely be the victim's choice and supported monetarily by the offending physician and the college which licenses him or her, whom it is responsible for as well.

It was proven that had even one of these therapists reported my assault, other women could have been spared this man's harm. Nobody even suggested, let alone asked me about, reporting, and then there was never a suggestion of seeking redress for the assaults done to me and my son.

If the processes of discipline were made much safer for accusers, then it is our first belief and conviction that many more assaults would be reported. It could be a validating experience rather than a rape, as now presently exists.

There are a few good therapists out there, but that's all. What we have heard from the psychological community around this bill and its assessments is downright dangerous. I repeat: dangerous. Surely in the 1990s we all realize that street education far outweighs academic theory by a long shot. Simply put, if you haven't walked the walk, don't talk the talk.

Another grave concern that we've heard from these professions is their concern over misinterpreting touch. Again they don't know what they are talking about, obviously haven't listened to us and are foolish in their assumptions.

Examples: My daughter was examined by a neurologist for which I was witness at her request. She was asked to completely disrobe, including all underwear, and even though she had a gown on, it was open at the back and she had to parade herself for this offender under the guise of examination. My daughter broke down to me while getting dressed, saying she felt strange and violated and bad. It took me three hours after that examination to help her deal with this assault, a case where the doctor didn't touch her, but he assaulted her anyway.

On the other hand, I have been receiving massage therapy for my myofibrositis by a male massage therapist. He has shown me complete respect and never once have I felt anything but integrity and healing in his care.

It is apparent nobody seems to get it, that touch isn't the problem. It is the sexualization of thought and acting on it that is the problem. So let's get with the program. Listen to survivors, for heaven's sakes. They are the knowledgeable ones and they know what they are talking about.

Now a nimble list of the losses I've incurred: The termination of my first marriage as my husband wouldn't support me confronting Cameron; a breakdown due to exhaustion 18 months after the assault, resulting in my children never being with me on a permanent basis again.

Poor therapy put me back in a vulnerable state and I was sexually attacked, once again triggering the feeling part of the memory of Cameron's assault. My second marriage terminated just before the hearing commenced as my husband wouldn't support or understand my pain and my need to overcome it in seeking redress. In this redress I was revictimized, traumatized and, in short, my mouth taped in the name of no legal protection while I was publicly gang-raped. I was cross-examined mercilessly without intervention, reprimand, legal protection or therapeutic counsel to help me with the trauma.

I was psychiatrically labelled with disorders when they were appropriate orders of survival, but was smeared for these very techniques. I was wrongfully psychiatrized and hospitalized as a result. My credibility was attacked. My character was slandered and my profession slammed because I am an actress and singer, as well as a businesswoman.

I was put on trial for accusing a doctor of sexual assault. My intelligence was put on the rack, my heart bludgeoned with the harpoons of cross-examination. My emotional legs were spread wide open for the world to examine, my spiritual guts graphically ripped apart, the intimacy of my bedroom stalked and now I can't even enjoy the sexual pleasures and comforts as I once did because of the testimony of the ex-intimate.

I was betrayed and lied to by the college. Most of my family has abandoned me. My children have become estranged over the hearings. Friendships of 20 years no longer exist, my sense of humour turned to the macabre.

My solitude and peace of mind have been replaced by unmentionable thoughts. I am no longer armoured for the abuse our society is awash with. My artistry is intruded upon. I've lost singing engagements because my emotions aren't healthy enough to perform.

I've lost incalculably in my tenure, income and potential gains in business. Two of my companies have become dormant. Several creative projects have been shelved. I have fallen behind in computer skills and the development of the latest business technologies. I can't keep abreast of my paperwork for the first time in my herstory. My taxes are way behind. Legal action is being taken for failure to maintain a business contract as I have no funds left. I've used up all my RSPs and savings. My credit rating has plummeted. I can no longer concentrate on or afford my continuing education. I've spent virtually 12 hours a day for the last 18 months defending myself and licking my emotional wounds, so I haven't been able to have a conventional job.

Now, I am forced barely to exist on social services. I've lost my home, sanctuary and place of healing. I have no fixed address. Because I haven't been physically beaten by a spouse in the last six months, it doesn't constitute an emergency to get affordable, safe, private housing. It's now difficult to get proper medical treatment. I have scrambled thinking. I can't process under



stress. I have anxiety seizures, post-traumatic stress disorder, diffused myofibrositis, which is like being hit with an emotional Mack truck and every fibre in my body hurts.

My doctor dropped me after Cameron's verdict came in. One week before I was forced to leave my home at my most vulnerable time, I again was sexually assaulted by a chiropractor during a treatment for myofibrositis. I've lost everything and then to top it off, sexually assaulted again by a regulated health care professional because I was made so vulnerable. Now I'm being threatened with legal action because I spoke out about him.

There are those in this arena who have the audacity to suggest a \$10,000 price tag be hung on my life for therapy to get over these assaults in a year, and further suggest this money should go back into the very systems that assaulted me in the first place.

This, ladies and gentlemen, is not only the ultimate insult, it's scary to think that supposed intelligent, informed people would even consider this further atrocity, let alone be concerned with having to make responsible monetary amends to the victims of these crimes. I thank you.

1830

**The Chair:** Thank you, Ms Danley, for your submission. I think we recognize clearly the difficulty for you to come before the committee, but we appreciate the fact that you have done that. I don't know if there perhaps are a few questions.

**Mr Jim Wilson:** Thank you for your presentation. Just a general question: I understand your points with respect to standing and a number of things that are addressed in the bill. Are you generally pleased with the legislation now?

**Ms Danley:** Except for those that I have mentioned and that the other survivors are speaking of. Those are our most major concerns.

**Mr Jim Wilson:** Okay. I appreciate that.

**The Chair:** We have the attachments to your submission and we have the video. We will be in touch on that and also to make sure it's returned to you.

**Ms Danley:** Fine. I would like to let you know that I'm again appreciative of the opportunity to speak and appreciative of the fact that the Ontario government is addressing violence against women. I would be happy to make myself available at your convenience for any further consultation.

**The Chair:** Thank you very much.

ONTARIO PSYCHIATRIC ASSOCIATION

**The Chair:** I call our next witnesses, from the Ontario Psychiatric Association, if they would be good enough to come forward.

Welcome to the committee and perhaps you would be good enough to introduce yourselves. Do we have a copy of your brief? I'm just searching through my—

**Dr Joan E. Bishop:** No, you don't.

**The Chair:** Do you have an extra copy? We can have copies made if—

**Dr Bishop:** No, we don't have a copy.

**The Chair:** All right. Then just go ahead and if there's time, we'll have questions at the end.

**Dr Brian Hoffman:** My name's Dr Brian Hoffman. I'm a psychiatrist. We're here representing the Ontario Psychiatric Association. This is a voluntary organization of psychiatrists. Psychiatrists are also medical practitioners. We number about 1,200 practitioners in the province. The association is devoted to improving psychiatric care and the knowledge, skills and attitudes of practitioners. We do this through meetings, case conferences and the literature.

I'm chairman of the legislative review committee of this organization and I came here to accompany another member of the organization who will give the main part of the presentation and I'll be available for answers at the end.

**Dr Bishop:** I'm Joan Bishop and I'm the president-elect of the Ontario Psychiatric Association.

Before I talk, I really have to respond to what the previous person was talking about. I spent a lot of years in private practice listening to my women patients, and one of the reasons I have recently gone back into academic medicine is that my major interest has been in helping my colleagues, helping the medical schools listen to the voices of women and try to educate them, particularly around women's health issues, women's mental health issues, from a woman's perspective.

With respect to the issue of sexual exploitation of patients, my major interest has been on educating medical students, interns, residents and my colleagues about prevention of sexual exploitation, using the concepts of understanding the social context of women's lives and how women have really been oppressed by many of the institutions in our society.

I'm quite grateful that this legislation has come forth, because I think it is doing something to empower the exploited patients, the majority of whom have been women.

You've had lots of comments from lots of professional organizations on the bill. I choose only to talk about two things. One is the issue of mandatory reporting and the other issue is the subsequent treating professions for people who have been exploited by a health care professional.

On the mandatory reporting issue, as a practising psychiatrist I would have no problem with the mandatory reporting of sexual intercourse or other forms of physical sexual relations or touching of a sexual nature, even if the patient told me that they didn't want me to report them. To me, these are grave and serious injustices that are done to the patients. I think that part of the legislation is a workable one and actually would, overall, benefit patients.

Where I would have more difficulty is in the third category of sexual abuse, and that's having to do with behaviour or remarks. Where I would have the most difficulty is when my patient tells me about these and then says: "But please don't tell anyone about it. I've stopped seeing my therapist, but I don't want you to tell



anybody because although they did these things and it upset me, I don't want you to harm them."

I've had this happen and it's really highly problematic for me because I was taught, as a physician and a psychiatrist, not to break your patient's confidences. I have to feel quite certain, when I break their confidences, that I'm doing them more good than harm. That's why I think it's more problematic for virtually instantaneous mandatory reporting of remarks and behaviour of a sexual nature.

When this happens to me, I would certainly obviously follow whatever the law is. I think most of my colleagues would actually do that. But it is quite difficult if the patients really don't want you to do that. The suggestion of the duty to intervene that the health coalition had suggested, where there was a series of things that you could do before you embarked on mandatory reporting, particularly for the words and gestures, seemed to be some kind of a compromise to that difficult situation.

Again, I would really like to emphasize that the problem there is not the actual mandatory reporting. The problem is doing something that your patient doesn't want you to do, if they request that you don't do it.

The second issue that I thought seemed worth addressing is the issue of the subsequent treating therapist. The legislation as it stands states that the subsequent treating therapist does not have to be a member of a regulated profession. My concern with that would be that I understand the reason this bill is being drafted is to offer more protection by regulating professionals who will be treating people with problems, so that there is then a regulatory body that can police the actions of the professionals. If the patients who have been already victimized go and see someone else and it turns out that subsequent treating professional isn't a member of a regulated profession, how are those patients, if they get subsequently victimized, going to get any redress?

1840

I don't have an answer to that, and I realize that there may be—for instance, the social work profession isn't a regulated profession and there are a lot of really good social workers who would be obvious candidates for doing good therapy with patients who have been abused by other health professionals. There may be some way of dealing with that profession by profession or something like that. But to me, to leave people who have already been victimized open to a process that may unintentionally revictimize them and then they wouldn't have any recourse seems inconsistent with the intent of Bill 100, which I understand was to prevent the process by getting more regulations.

Those are basically the only two things that I thought we should emphasize today. If you're interested, I don't have a copy of the brief but I do have some information of papers that I published on prevention of sexism in medicine and guidelines for management of family violence, which are papers that I had published on behalf of the Canadian Psychiatric Association just to demonstrate some of the interest that I've had in this area, in case any of you aren't aware of these.

**The Chair:** If you could leave those with the clerk, we could have copies made for members of the committee.

**Dr Bishop:** I brought 12 copies, enough for the committee members, if you're interested.

**The Chair:** Oh, you did, fine.

**Dr Bishop:** Again, they relate to the issues that are being dealt with here, but it isn't the brief that we're presenting.

**The Chair:** That would be helpful to have. If you could give them to the clerk, he will make sure the committee members receive them.

**Dr Bishop:** Do you have any questions at all?

**The Chair:** Does that conclude your formal presentation?

**Dr Bishop:** Yes.

**Mr Jim Wilson:** Thank you for your presentation. The ministry has indicated that it's going to show us language with respect to a proposed amendment to the amended bill, which, in dealing with clause (3)(c), part three of the definition regarding behaviour or remarks, although there's mandatory reporting right through the definition, there are different levels of treating the different parts of the definition. For example, as you know, clause (3)(c) doesn't necessarily have to go to discipline, but the college may recommend assessment and possible remediation.

Does that do anything to alleviate your concerns? Or your concern, so I'm clear, is strictly on the reporting end of it?

**Dr Bishop:** My concerns are from the point of view of the patient. If they don't want me to say anything, I have to feel that whatever I'm going to do is going to help them in the long run. Again, as I said before, it may be in that situation if six months from now, after they feel stronger as a result of having someone believe their stories and validate the pain that they have experienced and listen to them and let them come to the position of strength where they can actually agree to have it reported, then I would see that as an ideal result, because then they would say, "Yes, I'll let you do it." The problem is when they say, "No, you can't say that." That's the problem for me.

**Mr Jim Wilson:** The way you see this legislation, and I tend to sympathize with you on this point, in treating a patient—I get the impression from psychiatrists that there's no optimum moment, or it's not very clear when you should have the discussion about reporting.

**Dr Bishop:** If anybody ever told me, I'd certainly have a discussion immediately to give them information that this is inappropriate behaviour, no one should be subjected to that sort of inappropriate behaviour, and: "I will give you the telephone number of the college because this is something that you can complain to the college about and, if you need help in formulating the complaint, I will do that. I'll do whatever I can to help you in that process." That's not the issue. The issue is if they say, "No, don't you dare do that." That's the problem.

**Dr Hoffman:** Along the same lines, you sometimes

have to think about why would a woman not want it reported, which may seem strange because she's told someone. But if she told it knowing that at some point someone is going to approach her again, it increases her level of anxiety. That doesn't go away easily.

In addition, sometimes you don't know what pressures the female patient might be living under with her husband or family members who are pressuring her not to report it, and once that becomes known, she's terrified—and this in fact happens fairly regularly, the woman is then thrown out. So until the woman can gain some control of her life and say, "Now is the time I can live with this anxiety and this risk," you wind up taking away the patient's autonomy and making decisions that have some danger in a society that otherwise isn't perfect.

If it were a perfect society, she'd be able to protect herself and her husband would understand and the family would understand, but we don't live in the perfect society. So the patient must be in control of these decisions, until it becomes of such a severity that there's an overriding public good. That's why we think there's a need to separate (a), (b) and (c).

**Mr Jim Wilson:** I understand. Your point has been made often. I'm going to ask that question to the parliamentary assistant. What were the discussions or the thoughts of the ministry around the question of the patient's right to not have this go to mandatory reporting, the patient's right not to report?

**Mr Paul Wessinger (Simcoe Centre):** I think the first answer to that is that the indication is that in the bill, of course, you require the consent of the patient before the patient's name is disclosed. It was felt that, even though these reports would not be acted on without the name of the victim in the report, it would be very useful to have this type of information for the college.

I think in particular if you've got, for instance—I'll give you an example—a succession of complaints about a particular medical practitioner, even though without the name disclosed, it might then cause the college to say, "Perhaps we ought to investigate this particular practitioner's practice independently." That might be one aspect.

The other is that there might be an aspect if the reporting was of, say, the verbal or behaviour aspect, the item (c), then it might be appropriate to independently consider the need for some sort of remedial action, some re-education or something of that nature that the college might consider, for instance, if you had even just, say, geographic. If you had a particular area that had a problem arise with respect to inappropriate remarks, it would certainly give an indication to the college that it might be appropriate to have some sort of educational programs in that area.

**Mr Jim Wilson:** But even if all this is explained to the patient and the patient says, "Fine, I understand all that and I still don't want you to report it," it puts the treating practitioner in one heck of a predicament, I would think. Did you contemplate any absolute override for patients who say, "Look, I don't care if the state wants all this stuff collected, I'm the patient, I'm instructing my treating practitioner and I don't want it reported?"

**Mr Wessinger:** Except that perhaps I could indicate there is the test of reasonable grounds and also the test of the qualifying language with respect to seductive, exploitative or demeaning remarks. I think certainly hearing the comments they would at least be able to cull out those sorts of situations where they didn't feel that on reasonable grounds they fell into that category, and the ones that are demeaning or—I think it's important, the overriding—that the college has on record the fact that there may be a problem with a particular practitioner, because the name would not be disclosed.

**Dr Bishop:** One of the parallels I can draw is that over the years I've treated a lot of battered women who, it's obvious to me from the first moment I see them, are living in a very abusive relationship with a person who they, in my opinion, shouldn't be living with. But it hasn't done me any good over the years to try to tell them what to do, because often not only are they being beaten by this person, but they actually love some aspect of this person or they wouldn't have started to live with him in the first place.

Until they feel powerful enough to actually say no or call the police, I don't have a right to make them do anything. Even though I wish I could take them home and look after them, I can't do that. But my experience has been that if I help them by validating their situation and help them feel more powerful, they usually are in the end able to do something that's really very good for themselves to get themselves free of these abusive relationships. So timing is sometimes really important. If people have enough time to feel more empowered, they can actually let you help them more. But sometimes at the beginning they don't.

**Mr Wessinger:** The only thing I just might add is that survivors do overwhelmingly support the mandatory reporting of item (c).

**Mr Larry O'Connor (Durham-York):** I appreciate your presentation. One thing that concerns me, unless I've mistaken what you've said, is in section 3 where we talk about the different categories, (a), (b) and (c). You appear to be confident that the patient's confidence has been violated in cases (a) and (b) but perhaps not (c); or maybe I'm reading this wrong. I think that the violation is still there and perhaps you can expand on that a little bit.

**Dr Bishop:** It has to do with the level of seriousness of the violation of the patient, the level of seriousness of the abuse. It's clearer, I think, with (a) and (b) and not quite as clear in (c). Again, the only situation that I would really have difficulty with is if the patient really doesn't want me to. With the first two, I would feel more confident that I was protecting the patients more than I was harming them by mandatory reporting, whether they wanted to or not.

**Mr O'Connor:** In case (c) then, perhaps if the patient wants to make complaints, then it would be your role to validate that and to make sure that any information that was required would be there and you'd fully support them.

**Dr Bishop:** Yes, that's right. If that's what they wanted to do, absolutely.



**Mr O'Connor:** I'm still not comfortable with it. Have you seen the amendment to that?

**Dr Bishop:** Yes.

**Dr Hoffman:** I have one small comment about the words "exploitative" and "demeaning." The word "demeaning" is to my way of thinking far too distinct and far too broad. I would certainly agree with "sexually exploitative."

To make a judgement on "demeaning" which could be largely in the patient's eye rather than intent or in actuality—a gown, a look, an internal examination are all felt as demeaning; but were they demeaning?—is a jump that makes it very hard to put that in the category of mandatory reporting at all. I think that must be defined in regulations or elsewhere to make it practicable at all. It's just that one small one.

**The Chair:** Thank you very much for coming before the committee this evening. I'm just going to have the committee take a short adjournment so that they can grab a very quick sandwich and make sure that everyone is alive and able to pay attention for the rest of the evening. It will be a short one. We will adjourn until 7:15 and reconvene here at that time.

I might just mention to people, there is a ceremony that is about to begin in the main hall, so you might want to keep your eye out for that and not get caught up. We'll begin again here at 7:15. The committee stands adjourned.

*The committee recessed from 1854 to 1918.*

#### I KNOW NETWORK ONTARIO COSMETIC SURGERY HEALTH INFORMATION INC

**The Chair:** Good evening once again, ladies and gentlemen. We'll reconvene our hearings on Bill 100. Our first representatives are from the I Know Network Ontario, if you would be good enough to introduce yourselves and then please go ahead with your submission.

**Ms Kathleen Lumsden:** My name is Kathleen Lumsden of the I Know Network Ontario Cosmetic Surgery Health Information Inc. I would first like to thank you for the time to view our opinions here this evening. Also, we're not public speakers, so bear with us.

Through the past year and several efforts to try and set up appointments with the College of Physicians and Surgeons, as well as the Honourable Ruth Grier and the Ministry of Health, with no success in making these necessary appointments. With the ministry, we wish to approach that any type of bad surgery and the public must doctor-shop, as they call it here, sometimes going out of the country for testing and treatment for these problems at their own cost. This shopping for a doctor here at home has put a burden on the health care system, and additional costs which we otherwise feel not necessary if we had more protection against these abusive things by the Ministry of Health. A separate body other than the college for public complaints—as we feel, as it stands now, it smacks of favouritism. It would be our position that a separate and public body dealing with incompetency issues would not only seem unbiased and fair, but it would also serve as a valid sounding board in

dealing with public concerns relating to health issues.

I would like to read a small part from one of the college's discipline books. We have had a copy for your convenience to read. I will not read it all because it's quite lengthy. There were several doctors involved in this and partway on page 2, I believe the second paragraph—

**The Chair:** Sorry, is that one of the documents you've given us?

**Ms Lumsden:** Yes, it's from the discipline book of the college: Report of Proceedings, Discipline Committee.

**The Chair:** Oh, right; sorry. Here we are. Do members have that to hand? Dated March 1991? Please go ahead.

**Ms Lumsden:** There was a doctor monitoring a patient with hyperglycaemia and he did not prescribe strict diet or oral agents for insulin. As we go on, the dates are so close together. Then a neurologist was brought in. A Foley tube was used—still only a diuretic. I think most of us know that with a diuretic you lose the fluids from the body but will not have insulin. We feel that this is a sad case here where this woman had died from a misadventure, as they're calling it, from a doctor who was reprimanded at the college and left at that. They called it an unfortunate situation.

I called and wrote a letter about this and I said, "How dare you take life so lightly." When a doctor has not prescribed proper medication for the problem, then the doctor should be reprogrammed or retrained in the field. Why a neurologist? It should have been an internist in medicine who knows about diabetes. This lady doctor was only reprimanded; they saw no reason to teach her or retrain her or reprogram her. We feel this is inappropriate.

On the issues of sexual abuse and its definition and making mandatory reporting of any incidence of medical incompetency witnessed by another professional, we would heartily endorse such changes as we feel these changes are long overdue for the public's interest.

I would like to say there are more cases of people with health issues from surgery abuse and refusing treatment on the grounds that it was elective. Also when these ladies or men go for testing or treatment, they have been just pooh-poohed.

This, to me, is a form of criminal negligence, knowing a problem exists and refusing to help because of not wanting to be involved. That is why the I Know Network feels very strongly that mandatory reporting must be included in Bill 100.

I have many more issues, but I thank you for this time allowed to speak on behalf of the I Know Network. Before I leave, I would like you to hear from a victim of breast implants, in her own words, on what she has tried to live with, Ms Elayne St Pierre, one of the members of our group.

**Ms Elayne St Pierre:** Good evening. I'd just like to tell you a little bit about what's happened. I had implants 18 years ago and within two years of having them put in I became ill, but I didn't know it was from the implants and I had been to doctors all through the years. They said I had rheumatism; they diagnosed me with all these



different things. They gave me Valium for seven months; I developed an ulcer from that. To make a long story short, I've been from doctor to doctor. I've changed family doctors many times because I feel that they haven't helped me. Nobody could find out what was wrong with me.

In 1983, I requested a mammogram. At that time I was 40 years of age and my doctor didn't want to give it to me, but I demanded that I have it done because I had hardening and lumps in my breast and I had developed allergies, which I never had before. After I had the mammogram done, the doctor told me that I was fine, everything was fine, that I had nothing to worry about, that there was no evidence of cancer.

Well, through the years I got more ill. I was sick all the time. I developed fibromyalgia. I had sleep disturbance. I had chronic fatigue, allergies. I just kept developing all these things that I never had before. Then in 1982 I finally found a surgeon—the surgeon who had done my operation was deceased now—to remove the implants. When they removed them, my whole right implant was in fact gone. There was no bag; there was nothing. The whole thing had gone through my body and the left one was partially ruptured.

So when I got my medical records after the operation, I found out that the radiologist who had done the first mammogram in 1983 wrote in his report that I had two implants in one breast, when in fact I only had one. What happened was that the implant was clearly visible, that it was ruptured, and part of the implant had gone down into my armpit, which accounted for the lump I had under my arm which the doctor didn't know about.

But at the time you couldn't get your records. The doctor never asked me if I had two implants in one breast. The radiologist never asked me. So I just went away thinking everything was fine when in fact I had found out in 1983 that the implant was ruptured, I could have had everything removed and I probably wouldn't be as sick as I am now.

Therefore, I feel the medical profession, somebody, failed me with this. I landed up having to have breast reconstruction done. I had to lose part of my right breast tissue because of the damage that the silicone has done. I am still sick. I've done all the research on my illness myself. The doctors haven't done it for me. They've sent me to psychiatrists because they don't know what to do with me.

At this present time, I did find one doctor—I belong to a pain clinic which I found on my own—who is giving me some kind of help. I would just like to know: Where do people like myself go, you know, to get help? Why doesn't somebody just say they know what's wrong instead of keeping saying they don't know and doing all these things that aren't helping? I feel like, why couldn't they come up with some kind of a clinic with certain doctors just to treat people who have the problem that I have instead of all these thousands of dollars that are being spent on all these doctors we're going to and all these tests that we're having to have done? I'd just like to know where we stand with the Ministry of Health on this problem.

I could tell you more, but it would take a long time.

**Ms Barbara Kerr:** Good evening. My name is Barbara Kerr and I also am a victim of breast implants. I'm a member and volunteer of the I Know Network, Ontario branch, and I would just like to read briefly a letter, what some of my feelings are.

I met Kathleen Lumsden of the I Know Network Ontario Cosmetic Surgery Health Information Inc at the time when I was trying to survive a living nightmare, the same as Elayne. I identify with her 100% in a lot of issues.

I was a victim of silicone breast implants. Kathleen spent hours on the phone with me day after day reassuring me that she would be by my side through this terrible ordeal. Kathleen agreed it was not just a nightmare but it was in fact a reality and that I was not going off my rocker and I certainly was not the only one living this hell. She was determined to get the help I so desperately needed. Kathleen is diligent and does not take no for an answer when it comes to getting the information and help she needs for her ladies. Kathleen not only made the appointments I needed with the doctors, but she would come with me, again reassuring me of her support.

I would like to take this opportunity to thank Kathleen for everything that she has done for me and countless others in despair. It's through Kathleen's courage, determination and tender, loving care that I have made it this far. I'd just like to take this time to say thank you, Kathleen. On behalf of myself and all the other victims, thank you very much.

**Ms Lumsden:** I think you'll see some of our research added in there from Dr Campbell from Houston, Texas. We have sent many, many times to different doctors and we also have a doctors list there. It took us over two years to acquire doctors who were sympathetic and understanding enough to work with us to help these ladies. We now have a pathologist at one of the major hospitals helping us. We have Dr Pierre Blais, whom I'm sure you all have heard of, on medical devices in Ottawa. We have an immunologist, pathologist, neurologist, psychiatrists and cosmetic and plastic surgeons.

But there's only so much you can do. We're not funded and so far it's come out our own pockets. We also are trying to educate the public. Twice a year, we put forums on and bring these doctors in from Houston, Ottawa and our own here in Toronto and it's quite costly. I really feel the ministry should be educating the public, not the public educating the public and at their cost.

**The Chair:** Thank you very much, not only for your presentation but, as you've mentioned, a number of attachments to your submission which we'll have an opportunity to look at, and I thank you very much for coming before the committee.

1930

#### FEMINIST WORKING GROUP ON THE CRIMINAL (IN)JUSTICE SYSTEM

**The Chair:** If I could then call on our next presenters, representing the Feminist Working Group on the Criminal (In)justice System, we have a copy of your submission, Ms Bazilli. Is that correct?

**Ms Susan Bazilli:** Yes, Bazilli.

**The Chair:** Please go ahead.

**Ms Bazilli:** My name's Susan Bazilli. I work at Metrac, Metro Action Committee on Public Violence Against Women and Children, as a legal director. I'm a lawyer, but I also coordinate a group which we've called the Feminist Working Group on the Criminal (In)justice System, which is a coalition of a number of organizations in Toronto that work in the area of violence against women, and the list is in my presentation. You have it before you.

We set this group up a year and a half ago because we were getting more and more stories coming to us by women who were being not only violated, sexually assaulted and abused by perpetrators but also by the system, and while the title of the organization looks like we're dealing just with the criminal justice system, it's basically meant to say that the system is criminal and there is no justice for women in all the systems. So we work as advocates and work in the area of policy in the criminal law system, in the family system and in all the various tribunals that women find themselves in.

Most recently, for the past year, we've been involved in ongoing meetings with staff at the Ministry of the Attorney General around the release of the Martin committee report and crown directives, policy directives, that are going out to all crown attorneys on issues of disclosure and screening etc.

Just to give you a bit of background on the organization, we've worked very closely with survivors of sexual abuse, ranging from being abused by doctors, women who are incest survivors, women who've been sexually assaulted by strangers and the whole gamut.

I think it's really important that survivors are coming here to give their version of what's happened to them in the system because basically I think what we're dealing with—I mean, we all know what we're dealing with in Bill 100—is competing interests, and competing interests between people who are vulnerable and have no power and institutions that are extremely powerful in our society; namely, those of health care professionals.

I want to say that what you've heard from the survivors about how they've been treated by the system, specifically if they're referring to the College of Physicians and Surgeons, is no different from the experiences of women who've gone through any other kind of legal system.

Basically what we're talking about is what I see is an issue of fundamental human rights and justice, and we're talking about the fundamental human rights of women to seek justice through the various systems that are supposed to be in place to help women get justice, and we've seen very little of that in all of these systems.

So I want to pay a tribute to the survivors who have spoken to you and will be speaking to you in the next few days, and also for you to remember that the stories they're telling you about the systems that they've been in are exactly the reason why in all of the talk in the last two decades in this country around violence against women we know that violence against women is the most

underreported crime. That's precisely why it's so under-reported, because of the way women are treated by the system.

When Sharon Danley was talking to you about the experience she went through, it's very clear that one would question why anyone would want to put themselves through that system, ie, why they would want to report, and that's exactly the same with what happens in terms of sexual assault in the criminal proceedings. What we're looking at is trying to build systems that are accountable to the people who have needs to be met in that system so that we can encourage reporting and encourage the system to respond to the needs of those women.

The basic tenet of all of the systems, from my experience as a lawyer, is that women are not believed. Whatever the system women are caught in, women are not believed. Their experiences are not believed.

One of the reasons why we're glad to be involved in this process is because we're trying to build some accountability through the Regulated Health Professions Act so that we can have systems in place that will allow women to come forward, will treat women's complaints with dignity and that their complaints can be believed.

I don't want to read through my presentation. It's far too long to read. I just want to point out the submissions, basically the recommendations that we're making.

We believe it's very important that Bill 100 have a preamble and you'll read my notation on why a preamble is important and I direct you to the preamble of Bill C-49, which was the rape-shield law, the new sexual assault law that the federal government brought in last year, which felt that because sexual assault was a situation of such grave concern to all Canadians, that in a piece of legislation in the Criminal Code, which hadn't been done before, the federal government felt it was very important to set out a preamble stating the intent of Parliament. I would suggest that provincial Parliament do the same thing with Bill 100.

The definition of "sexual abuse": We agree with the definition as it's put forward, although we also request that sexual harassment be defined as well as when we're talking about behaviour and gestures. In fact, what we're talking about is sexual harassment.

We've seen all too clearly in the recent Walter Hryciuk hearings of the judicial council how sexual harassment is being defined in the eyes of the public and so I think we should call it like it is in Bill 100 and talk about sexual harassment. I also believe that you've heard we think it's very important that "female genital mutilation" be included in the definition of sexual abuse.

In terms of competence, we want the inclusion of "incompetence" as well as "professional misconduct," because there are a range of issues that will fall from having it being one or the other, and that is set out in my brief.

Definition of "patient": We think that "former patients" is important to include in the definition.

We support the regulation-making powers and we oppose the deletion of the regulation-making powers. We



think it's very important that colleges be empowered to make regulations.

**Mandatory reporting:** Clearly, we support mandatory reporting, although we do recommend deleting "in the course of practising the profession" for reasons which are stated in my brief.

I want to respond to some of the questions that were raised before the quick supper break about confidentiality and patients coming before a professional in the course of treatment, talking about sexual abuse by another professional.

I think it's very important that we all recognize clearly we don't want to breach the confidentiality of that patient or client, but that doesn't preclude confidential reporting going forward, ie, to report an incident with the name of the professional who has been reported, guaranteeing the confidentiality of the complainant, because clearly we've heard the reasons why women, especially at times when they're most vulnerable, would not want to go through a hearing. That's not to preclude that at some later date they wouldn't want to.

It's very important that we build a record of complaints against certain perpetrators so that at least we have on record the fact that complaints have been made against certain professionals so that when women come forward or when anyone comes forward with a complaint against that perpetrator, we already have on record somewhere the fact that they have been named as having abused patients.

I think it can be done. I think we can strike a balance between the confidentiality and the rights of the perpetrator so that we're building a record within the confines of that particular college.

The issue of standing, I think, is absolutely crucial. I say that as a lawyer who has been extremely frustrated in all of my work dealing with women who are victims of violence at how they're being brutalized by the system because they don't have legal representation. Whether it's in the criminal system, whether it's in tribunal situations, women's interests are not represented by prosecutors.

It seems, from my experience, that women's interests are only going to be represented when they have standing and when they have their own legal representation. The right to cross-examine, the right to call evidence, the right to do everything that a defendant in a criminal proceeding has the right to do or an accused person before any other tribunal has the right to do. It's absolutely crucial that women have independent legal representation in hearings.

1940

**The Chair:** Sorry. I know there's singing going on. There's a citizenship ceremony. I understand it won't be too long and I just ask for everyone's indulgence, but please go ahead. We're focused on you.

**Ms Bazilli:** I can talk over the singing.

**The Chair:** Okay.

**Ms Bazilli:** By the same token, I think it's also crucial that women's legal representation be paid for, that the costs be borne by the colleges and by the councils.

There's been some discussion around the standard of

proof. I want to make two points about the standard.

We're very, very concerned about what I heard someone refer to earlier about the quasi-criminal nature of hearings. We all know these hearings are supposed to be civil, and there is increasingly an importation of the criminal standard or the criminalization that's being brought into the hearings, which works to the detriment of complainants and often works to the advantage of the defendant.

I think it's very important that we acknowledge that it's a civil test, it's a civil standard, and also that the objective standard be one that is gender-specific, ie, that it's not the reasonable-man standard and it's not specifically the reasonable-woman standard, that it's gender-specific to the complainant. If the complainant is a woman, the standard is that of a reasonable woman, objectively, and if the complainant is male, then the standard is that of the reasonable male, objectively.

**A point on funding and compensation:** This point is going to be made before you over and over again, that the \$10,000 ceiling for the voucher that basically puts women back into the system is ludicrous. We're absolutely opposed to that position and we endorse the setting up of a victims' compensation fund.

When you read through my brief, you'll see that there are a number of places where I've actually imported information from the briefs that were written by survivors, because I don't purport to speak on their behalf. They can clearly speak very eloquently for themselves. So I've just given you excerpts from some of the briefs I've read that have been written about survivors and one point specifically on the survivors' compensation fund.

Another point that we think is really important is that evidence of past sexual conduct, when it's attempted to be used as a defence, is never relevant. Here we're not even talking about importing a criminal standard like we find in the rape shield law; we're just saying it's never relevant. End of story.

Finally, I want to make a point. I know it's not something we're going to deal with with Bill 100, but somebody earlier made the point about health professionals who were unregulated, ie, if women go to a therapist or a counsellor of their choice, what do we do in the situation where that person is not part of the Regulated Health Professions Act?

I think it's something we need to turn our minds to after Bill 100, but we could look at the omnibus legislation in California, where unregulated health professionals are actually subject to an omnibus legislation. Here we're dealing clearly, we all know, with regulated health professions, but we do clearly have a situation where there are abusers among the unregulated health professions. California was the first state in the US to deal with this through omnibus legislation, and I think if we turn our minds to that in the future, then we'll find a way of being able to deal with that.

**The Chair:** Thank you very much. Could I ask you one question just on your last point? Some of us around this table sat through it two years ago when we did the health disciplines legislation. I don't know if you were



familiar with those hearings, but there were a number of groups, some of which came forward to say they weren't ready to ask to become a group or organization with its own council to be self-regulating, but at the time the social workers were requesting either to be included within the registered health disciplines legislation or that there be some special piece of legislation through which they would then be self-governing.

The California model that you refer to: Does that encompass social workers, or has that essentially been passed, that omnibus bill, to capture all of the non-health counsellors?

**Ms Bazilli:** Health or non-health, whoever doesn't fit into whatever legislation is regulated.

**The Chair:** When was that passed?

**Ms Bazilli:** Last year, 1992. I don't have a copy of it. In fact we've spent months, actually, trying to obtain it, but I think we have it now and we'd be happy to give a copy of the California legislation to the committee.

**The Chair:** Thank you. Any other questions or comments?

**Mr O'Connor:** One, perhaps: One thing we heard—actually I think it was Sharon Danley's comment—was that they feel further victimized when they're turned back in to the system that victimized them when they have to go back there for therapy. I just wondered if you'd want to comment on alternative choices of therapy and the victims having the right to choose that.

**Ms Bazilli:** I think it's very simple. I think victims or complainants should have the right of choice to a therapist or counsellor of their choice, wherever they are in the system, if it's someone the individual feels comfortable with and trusts. Basically what we're talking about is having to rebuild trust in a profession globally where people have been victimized in the first place, so I think, whether it's regulated or unregulated, what we're talking about is a therapist or counsellor of choice.

I don't want to speak for Sharon, but I think when she said "turned back in to the system," she was talking about when you have no choice. You're just given a voucher and told, "You must go and see X, Y or Z in this particular system." Certainly in my experience, it's taken a long time for women to rebuild confidence in any treating person, regardless of where they are in the profession.

**Ms Haeck:** Thank you very much for your very excellent presentation. We've had a number of professional groups before us today, and one of them was the College of Nurses of Ontario. They've raised the point that they feel that somehow with the mandatory reporting for other professionals, where say a nurse is working with a doctor, there may be a hesitancy actually to get into the mandatory reporting for a range of reasons, which you've probably heard about. What are your comments with regard to those positions, because they're not the only ones who are raising this but they're the ones who definitely were here today.

**Ms Bazilli:** I guess if it's not made mandatory, then there wouldn't be any reason to report. If I could editorialize, I would say that certainly if I were a nurse, I would be hesitant to report on someone who was higher

up than me in the profession and in the hierarchy. If I knew there was mandatory reporting built into legislation, that would safeguard me in being able to report, because it would be there in the law. We have comparable statutory legislation in terms of reporting child abuse. I would think it would actually provide a safeguard for people who didn't feel comfortable in reporting.

**Ms Haeck:** What about the OMA's coming forward with what they call sort of the duty to intervene? There are several steps to their procedure for dealing with this, one of which is that for the professional who hears from the survivor, or the victim, that a colleague may have abused, it's then up to the doctor who has heard this complaint to possibly go and talk to the professional and try to sort of intercede on the patient's behalf. What is your response to that?

**Ms Bazilli:** I heard you raise that earlier. I haven't seen those recommendations. Without seeing the details, from what you're telling me, I would be opposed to it, because what we're talking about is accountability in systems, not individuals being empowered to go and intervene on other people's behalf. We're talking about professionals being accountable to a system. We're talking about building public trust, because we all know it's a minority of people who are abusing, but the public confidence has been lost to a great extent. I think that would just increase a loss of public confidence if individuals were given bits of power here and there to try and intervene at an individual level. This is a systemic problem, not an individual problem.

**Mr Jim Wilson:** I don't have a question for the witness, but I do thank you for your presentation. It's the second time Ms Haeck has raised the duty-to-intervene proposal put forward by the OMA. I would simply ask members to re-read that because it only deals with clause (3)(c); that is, with behaviour or inappropriate language, and it does not deal with the whole definition of "sexual abuse."

1950

**Ms Bazilli:** Okay. I didn't know that.

**Mr Jim Wilson:** It's actually in parallel with what the government itself is suggesting through amendments. I don't think we want, for the second time this evening, to leave the impression that it deals with the whole definition of "sexual abuse," because it doesn't.

**The Chair:** Thank you very much, Ms Bazilli, for coming forward. Your brief does, as you noted, have a lot more in it, and we appreciate what's there.

ONTARIO MESSAGE THERAPIST ASSOCIATION

**The Chair:** I call on the representative from the Ontario Massage Therapist Association, if you would be good enough to come forward.

**Mr John Sanderson:** My name is John Sanderson. I'm a registered message therapist and executive director of the Ontario Massage Therapist Association.

Our association commends the government for the introduction of Bill 100. It's a starting point for dealing with a very difficult issue. We have participated at every step of the process of developing legislation which will be effective, efficient and empowering without compro-

mising the rights of the innocent.

Tonight, I want to tell you about a special concern massage therapists have concerning interprofessional reporting of touching of a sexual nature.

Let me put it in a nutshell for you: To a greater degree than any other health care profession, massage therapists touch people. Under the present constraints of Bill 100, much of what massage therapists do could be interpreted as touching of a sexual nature. As a profession, we are concerned how other health care providers will perceive and interpret our work within the guidelines and definitions set out by Bill 100. We are concerned that much of our work, our everyday treatment practices, may be interpreted as inappropriate.

I'd like to begin by telling you a story. Picture this scenario: A physician refers a woman for massage therapy for treatment of upper-back and neck pain and headaches. Part of a massage therapist's assessment of this woman would include determination of what type of work she does, what kinds of rest breaks she gets, whether she has freedom to stretch during the work period and what the shape of her work station is.

The treatment program would include a description of involved muscles, the origin of her pain, an explanation of the proposed treatment and a recommendation of prescribed stretches and exercises. In this instance, her back and neck as well as the muscles of her neck and chest would be treated.

The next time the woman returns to her physician, she may advise that treatments are progressing well, her headaches are gone and her back feels better. She may also add that the therapist has been working on her chest muscles, in particular her pectoral muscles, which begin at the sternum and extend out to the shoulder, passing directly beneath the breast.

I ask you, under Bill 100, could this constitute touching of a sexual nature? Would the physician report it as such? We believe this could happen. Let me explain how, by first giving you some background about massage therapy, before discussing the legislative provisions.

Massage has been around for a long time. Hippocrates, the father of modern medicine, recommended working with the muscles to promote health, as did other ancient physicians. Massage therapists practise holistically, which means we address and treat all parts of the body. Although Western society gives the connotation of "private" or "sensitive" to certain parts of the body, the profession of massage therapy does not promote that view that certain body parts are more or less important than others.

Our clients tell us and survivor groups tell us that healthy touch is a significant component of healing, so by ignoring or shying away from working on sensitive areas, a massage therapist would not act responsibly. Denying complete treatment and the healing benefits of touch would be contrary to a holistic approach. Yet Bill 100 could lead to a moderation of treatment to protect the therapist at the expense of the client's health.

In the example just given, the patient's neck pain would require massage of the chest muscles. In other

instances, other sensitive areas could be treated, such as the buttocks during a low-back or a leg treatment, or adductor muscles for groin pulls. In our view, without any concept of exploitation in the definition of "sexual abuse," all of these treatments could constitute touching of a sexual nature.

Therefore, the Ontario Massage Therapist Association supports the concept of exploitation as a necessary component of the definition of "sexual abuse." Exploitation would indicate that a wrongful action had been knowingly committed by the health care worker within the context of the client-therapist relationship. An exploitation formula would serve to prevent cases such as the example cited above from being reported.

Massage therapists in Ontario are well-trained to communicate clearly and to respect their clients' right to privacy. We protect ourselves from misunderstandings by explaining procedures, the pros and cons of treatment, therapeutic objectives and by asking for informed consent. However, clients who are in acute pain or who are experiencing the beneficial effects of endorphin release after a treatment are not always able to concentrate fully. No amount of explaining will provide a client with an accurate memory.

Having explained how accepted massage therapy techniques could be misconstrued as inappropriate touch, I will now address my main point, the problems inherent in cross-professional reporting of this category of sexual abuse.

I acknowledge that my training does not provide for an adequate understanding of all the techniques of palpating, assessing and treating employed by chiropractors and physiotherapists. How can we expect a practitioner from a discipline where touch isn't integral, such as a dietitian or speech pathologist, to know whether certain conduct is appropriate? The filing of a report under such circumstances would have significant negative consequences. It would occupy college time and resources and might lead to an entirely unnecessary investigation. It would cause anxiety and potential harm to a practitioner as a result of what was essentially miscommunication.

Now let's consider the situation of a massage therapist who has determined that breast massage is clinically indicated. While not part of every massage treatment, there are instances in which breast massage is appropriate. Generally speaking, long-standing conditions of poor circulation and drainage can jeopardize breast health. Many common practices may contribute to circulatory and lymphatic congestion and poor breast drainage, such as restrictive clothing, adopted postures to reduce attention to breasts, surgical scarring and implants.

Prior to treatment, considerable discussion would take place with the client as to the reasons why breast massage is indicated, the benefits of the treatment, the safeguards and the privacy protections which would be in place, and a mechanism for the client to stop the treatment should she desire.

Given the high incidence of breast disease in Ontario, the massage profession cannot justify overlooking the necessity for preventive and case-specific treatment. In fact, it is important to be aware that our society's inabil-



ity to consider breasts neutrally from the point of view of tissue needs has perhaps contributed substantially to what could be considered one of our most underrated health care crises. Consequently, on August 26 of this year, at a meeting of Ministry of Health staff, coalition members, college members and survivor groups, many in attendance were astonished to discover that breast massage was a therapeutically sound treatment offered by registered massage therapists.

Tonight, I briefly commented on the definition of "sexual abuse" contained in Bill 100, in particular "touching, of a sexual nature" and its inherent ambiguity as it applies to our profession, and addressed the issue of interprofessional reporting of this type of touching and the potential for misunderstanding.

Registered massage therapists have progressed beyond the media and societal stereotypes of massage and provide a viable and necessary component of health care in Ontario. We wouldn't have been considered for inclusion in the RHPA had we not proven ourselves. Now we ask that we be allowed to practise the art and science of massage therapy without the constant fear of reporting or the feeling we have to compromise the work we do at the expense of our clients' health.

Massage therapy is one of the few health professions where touch is the primary means of treatment. Therapists educate clients about the quality of touch they receive, empowering them to take control of their own health and healing process. By imparting clear and positive messages about each part of their clients' bodies and about what needs attention, massage therapists help to heal a lifetime of pain, overuse, misuse and abuse. Yet our work is often misunderstood by the media, the public and other health professions. The difference between the professions, our training and scopes of practice, make it unlikely that we will be able to adequately and justly determine if there has been an incident of touching of a sexual nature.

2000

**Mrs Irene Mathysen (Middlesex):** Mr Sanderson, you seem to have presented a bit of a dilemma and I'm not sure that you've given us a resolution to this dilemma. On the one hand, you're saying there's great support for Bill 100 and the very serious problems it addresses, and then you voice concern about how it may affect massage therapists.

I'm wondering, is there a solution? I was thinking as you were speaking that surely a complete and open discussion between therapist and patient, to determine that the patient understands and feels comfortable with the treatment, would go a long way. I need your help on this. I don't know exactly what the solution is.

**Mr Sanderson:** I don't perceive the problem as being between the therapist and the patient or client; it's more when another professional hears about that treatment, or is told about it. Often we find our clients do not remember the explanation as to why something is indicated.

I see the answer as being education among the professions so that all the professions understand what therapy does, but I don't see that's workable in the foreseeable future. My intent of being here was more to

provide insight and information that might otherwise not be provided, just because we're not well understood as a profession.

**The Chair:** Parliamentary assistant.

**Mr Wessinger:** I'd like to ask you a question. On the matter of touching of a sexual nature, I think it's quite clear: Where it's therapeutic or clinical touching, it's not of a sexual nature. However, would it assist at all, for instance, if you had it clarified, do you feel, in the legislation, when you said it did not include, say, touching of a clinical nature appropriate to the service? Would that be of any assistance?

**Mr Sanderson:** That would be the direction I would like to see, and further clarification, yes.

**The Chair:** Thank you very much for taking the time and coming before the committee this evening.

#### ONTARIO COLLEGE OF PHARMACISTS

**The Chair:** I then call on the representatives from the Ontario College of Pharmacists. Welcome to the committee.

**Ms Madeline Monaghan:** Hello, my name is Madeline Monaghan. I am the president of the Ontario College of Pharmacists. With me is Jim Dunsdon, who is the registrar of the college, and Christina Langlois, who is the manager of the patient relations department at the college.

I have brought copies of our submission which I hope you will receive and follow through with me. Our submission is relatively brief. We just really have a few concerns which we wanted to bring to you this evening.

**The Chair:** Fine. Please go ahead and we'll catch up.

**Ms Monaghan:** The Ontario College of Pharmacists is pleased to have the opportunity to make this submission to the standing committee on social development respecting Bill 100.

The Ontario College of Pharmacists has been the licensing and regulatory body for the pharmacists of Ontario since 1871. The college's mission is to contribute to the health and wellbeing of the public of Ontario by ensuring that pharmacists provide optimal pharmaceutical care, and its purpose is to protect the public.

There are currently some 8,140 licensed pharmacists on the college register and approximately 2,400 accredited pharmacies in Ontario.

The Ontario College of Pharmacists supports the aims of Bill 100 in principle and is committed to a goal of zero tolerance of sexual abuse within their profession. The college's comments on Bill 100 are made with a view to ensuring that this important legislation is workable and effective in achieving these goals.

Generally, the college supports the positions taken and the recommendations made by the Coalition of Colleges and Transitional Councils, which I know you have heard before this time.

We will take this opportunity to address a few matters of particular concern to our college.

**Definitions:** It's important that there is a clear definition of "sexual abuse" in the legislation for the purposes of successful prosecution as well as mandatory reporting.



The college takes the position that behaviour or remarks of a sexual nature should not be reportable on a mandatory basis. We place a great deal of emphasis on patient counselling in the pharmacy setting. In the course of counselling patients, it is possible that a third party may overhear remarks that on the surface appear to fit the definition of "sexual abuse," which are in fact appropriate to the subject matter being discussed with the patient.

Being in a practice environment myself, I know there are situations when I talk to patients about the side-effects of their drugs, which may affect their libido or their sexual activity. We try to discuss with patients whenever we can. It's not always a private situation when you're dealing with a patient in a pharmacy. It's often very busy. Other people are listening. So a lot of the things that I could say to my patient could be thought of as sexual abuse.

There's the situation of the HIV patient whom I have to speak to about the use of condoms and other things that are very personal and difficult to relate without giving the impression that there may be some problem with the discussion. We counsel patients on how to apply creams, how to use all kinds of other devices, which we feel are really very delicate situations. We try very carefully to make sure we're talking to the patient in an environment where they feel confident and able to speak. However, sometimes someone overhearing that could misinterpret what our intention is.

It is our feeling that requiring mandatory reporting of behaviour and remarks could cause members to shy away from patient counselling, which would not be in the public's best interests. The college would recommend that the definition be amended to include "inappropriate to the service being provided" in the behaviour or remarks section.

The college supports the Ministry of Health's proposal to amend Bill 100 by removing the ability of colleges to further amend the definition of "sexual abuse" through regulations. It is the college's opinion that this would make mandatory reporting across the various professions covered by RHPA impossible, as each college could potentially have its own unique definition of "sexual abuse."

The college of pharmacists is concerned that Bill 100 does not contain a definition of "patient." Although it may be clear in other professions who is and who is not a patient, it is somewhat less clear in the community pharmacy setting. The college would recommend that a patient be defined as "any individual who receives pharmaceutical services at a pharmacy."

I often think of a situation where someone may come into a pharmacy and ask advice from a pharmacist, but the pharmacist does not know the name of the patient, doesn't know any background of their medical history, and perhaps the patient leaves the pharmacy without even purchasing anything. However, something that could be said may be interpreted. We're concerned about professional and personal relationships, which I know other colleges have mentioned as well. So we think it's very important to identify who the patient is, particularly in our situation.

We have a comment about non-party participation at hearings. The college is concerned about the effect that non-party participants will have on the disciplinary process, traditionally a matter between the college and the member. Although the college accepts the participation of non-parties in hearings where necessary, in the sole discretion of the discipline panel, it objects strenuously to any extension of intervenor status beyond that which is provided for in Bill 100.

While the college recognizes that victims of sexual abuse may require funding for counselling, we feel that it is not an appropriate role for the college to play. We feel that it would place the discipline panels in an untenable conflict-of-interest position. Colleges have never been involved in awarding money to individuals who may have been harmed by a member's actions. These are matters we feel are better left to the civil courts.

Should the college be required to provide funding, the Ontario College of Pharmacists would want to administer its own fund, rather than contributing to a fund which would pool resources.

The Ontario College of Pharmacists appreciates the opportunity of providing this submission to you on this very important piece of legislation. At this time, I'd ask if there are any questions.

2010

**Mr Jim Wilson:** Thank you for your presentation. It's always good to hear from the college of pharmacists, particularly after the smoking announcement last week. We probably disagree on one point of that announcement.

Two things: One is that perhaps legal counsel could provide us with whatever definition of "patient" we're to use in this act. Secondly, I want to talk about the very last point, because it was made last week on the one day of public hearings we had. That was about what does appear to be an inherent conflict of interest from beginning to the end of this process, given that it's all contained within the member's own college.

It was actually suggested by, I think, the College of Massage Therapists of Ontario, and I might have the college wrong, but representatives, their new college starting up, that because they're also in the business of awarding money at the end of the process and there's a lot of money involved in the entire process, the way this whole thing's set up, it might be a disincentive for colleges to actually seek out those who are committing sexual abuse and prosecuting them and putting them through the entire process.

Everyone in this process being professionals, I doubt that would occur, but I thought it was a fairly astounding statement. You don't say it here but you do talk about the conflict of interest. Do you have any comments on that, that there might be a built-in disincentive to actually wipe out sexual abuse?

**Ms Christina Gauthier:** I don't think there would be a built-in disincentive at all. After all, we're here to protect the public and we would actively pursue individuals who were part of the profession who were doing something wrong.

I think the difficulty arises from the perception of conflict, not just from within our college but also from without. It's difficult for the public to look at a body that's involved in not only prosecuting but also hearing and then awarding damages, all in one setting, not to perceive some conflict.

The other difficulty we see is from the member's perspective, perhaps also seeing a conflict of interest, but frankly I don't think there would be a disincentive to eradicating abuse from the profession. I can't imagine that would cause it.

**Mr Jim Wilson:** Even if the college goes bankrupt as a result of this legislation, especially some of the newer, smaller colleges?

**Ms Langlois:** We're not in that position, fortunately, not being a newer, smaller college, but certainly having looked at the numbers and the kind of funding that is required to be kept at a minimum in these funds, I could see how a smaller college would have a great deal of difficulty funding even the basic requirement. What that would mean to them I don't know, and whether bankruptcy would be a potential, again I would not want to comment. But certainly it's a large burden that some colleges may be under.

**Mr Jim Wilson:** Thank you. The definition of "patient" comes up time and time again. Would counsel or the PA like to comment on that?

**Mr Wessenger:** Yes, I'll ask counsel to comment on that.

**Ms Christine Henderson:** For the purposes of Bill 100, there is no definition of "patient" within the statutory provisions that are proposed. The government's position is that each panel of the discipline committee would consider all the circumstances before it in every single case to make the determination as to whether or not, at the time the alleged sexual abuse occurred, that person was in fact a patient.

**Mr Jim Wilson:** Any comment from the college?

**Ms Langlois:** I think it provides some clarification, certainly. One of the other concerns we have as a college is from an educational standpoint. I know this is certainly an extension from Bill 100, but some of the discussion revolved around when professional relationships should cease if a personal relationship were to begin.

I think again that's an area where we're looking for a definition of "patient." If someone who comes into a retail community pharmacy and purchases something from the front shop, our pharmacist needs to know, as a professional, whether or not a personal relationship with that individual is inappropriate. Again, it's sort of away from Bill 100, but that was another aspect we were looking at. But certainly what you've just said is very clarifying for us.

**Ms Haeck:** You mention, on page 4, the funding mechanisms, and you are very clear in your final statement about the fact that you do not want to pool, that you want to have your own fund. One of the groups last week indicated that it actually sees a solution for a number of the colleges as being the opportunity to pool. I think in some respects it answers Mr Wilson's concern

in that it is permitted, to my knowledge, for a number of the colleges to actually pool their resources and deal with the situation. I would suspect that those colleges wouldn't find themselves in the same financial straits as they might if they were on their own.

Yet again, I want to ask a question. Have you had any cases of sexual abuse within your college and do you foresee that your funding mechanisms will not be able to meet the formula that has been put forward?

**Ms Langlois:** We have not had any experience to date with sexual abuse cases brought forward to discipline, so unfortunately we really don't know. Obviously the average would be that the \$10,000 would be required to be kept in the fund, but we have no experience to speak of, so unfortunately we can't really tell you much more than that.

**Ms Haeck:** No, you've answered my question. That's all I can ask. Thank you very much.

**Mrs O'Neill:** I'm interested to hear that you think it was helpful to hear the definition of "patient," because I didn't find that terribly helpful. We've had other presentations today that talked about "former patient." In your definition a patient would be defined as "an individual who receives pharmaceutical services at a pharmacy," so that would be the pharmacist and the patient at that moment, I presume.

**Ms Langlois:** Correct.

**Mrs O'Neill:** You suggested some people walk in—and they're not going to do any real business with you but they may have done business with another pharmacy—asking your opinion about that treatment or prescription or direction, whatever they were given.

**Ms Langlois:** That's correct. You may not know the patient's name, anything about their background at all.

**Mrs O'Neill:** It's only through recently having gone through a serious illness with a family member that I realized how much advice is given by pharmacists—I had no idea—and how much follow-up, and even sometimes follow-up going into the home with certain long-term care patients. That, I understand, is totally voluntary. But it's much more complicated, I would imagine, than many of us realize in your profession. I think there's a rather limited idea of what you do in comparison to reality.

When you're suggesting that the college take the position that "behaviour or remarks of a sexual nature should not be reportable on a mandatory basis," are you asking, as a psychiatrist did, for discretionary reporting, or would the phrase that you have at the bottom of page 3 be enough to satisfy your needs? I'm trying to put those two parts of that paragraph together.

**Ms Langlois:** They are somewhat confusing in the same page, I understand. I think that the paragraph at the end, which asks for a definition of sexual abuse in the words and gestures category to be expanded as "inappropriate to the service provided" would certainly go some way to allaying the concerns that we have.

Again, it might be difficult for a third party passing by to even know what was appropriate to pharmacy services, because as you've just very eloquently put it yourself, it's difficult sometimes for people to know the extent to



which pharmacists are involved in patient counselling and pharmaceutical care beyond the strict dispensing function. So it's not so much only for our members, but also for other professionals who might be listening, passing by, and being under an obligation to report themselves.

**Mrs O'Neill:** I would imagine there are more and more demands all the time.

**Ms Langlois:** Definitely.

**Mr O'Connor:** Mr Chair, am I allowed to pursue that?

**The Chair:** Sorry, I've got several others. I'm very mindful and I regret that we are late, and I'm going to have to close it off with having had one from each caucus. I apologize for that, but we'd be here till midnight and I don't know that our brain cells would be working that well.

I thank you on behalf of the committee for coming before us this evening.

2020

#### BOARD OF RADIOLOGICAL TECHNICIANS

**The Chair:** If I could then ask the representatives from the Board of Radiological Technicians to come forward, welcome to the committee. If you would be good enough to introduce yourselves, then please go ahead. We have a copy. Just for members, it was distributed earlier this afternoon, so everyone should have it in their packages. It's a little school test we have to do.

**Ms Janet Morgan:** I'll carry on with the introductions while you're finding it. My name is Janet Morgan. I'm a radiation therapist and I'm past chair of the Board of Radiological Technicians, soon to be the College of Medical Radiation Technologists. With me today are Sharon Saberton, our registrar at the board, and Debbie Tarshis, the legal counsel for the board.

My job as a radiation therapist involves treatment of cancer by application of high doses of radiation. Bill 100 affects all medical radiation technologists, including radiation therapists, in a very direct way, because in order to treat patients, we must touch them. Some touching can involve all parts of the body, including the genitals.

The Board of Radiological Technicians represents medical radiation technologists in three specialties: radiography, radiation therapy and nuclear medicine. We're the professional body that regulates medical radiation technologists, and we are the ones who will be implementing Bill 100. We are the ones who investigate reports of sexual abuse and who discipline abusers. It's for that reason that the board wants the bill to be effective and workable. I'm sure you've heard those words often.

The Board of Radiological Technicians supports the goal of zero tolerance and supports Bill 100 in principle. However, we are concerned that the bill is not practical and will not actually achieve its goal in a number of areas. These concerns are set out in more detail in our written submission. As you're already late, we'll try and limit our presentation tonight to our three main concerns.

The first is a definition of "sexual abuse," which will be used in two ways: first, to determine sexual abuse for

discipline purposes and, second, to tell practitioners what they must report. Because the failure of a practitioner to report sexual abuse can result in a \$35,000 fine, the definition must be clear. Even responsible practitioners will be confused about what to report if the definition is imprecise.

The definition has three parts: sexual intercourse, touching of a sexual nature and behaviour or remarks of a sexual nature. It is the third, the behaviour or remarks of a sexual nature, which we feel is very broad. It would be difficult to draw a distinction between permissible behaviour or remarks and offensive behaviour or remarks.

We would like to recommend that behaviour or remarks of a sexual nature by the member towards the patient be replaced so that it will say, "behaviour or remarks of a sexual nature by the member which are inappropriate and demeaning towards the patient." We've added to the definition the words "inappropriate and demeaning." The word "demeaning" captures a subjective test of the effect on the patient. The word "inappropriate" provides an objective test that distinguishes behaviour or remarks appropriate to the procedure or treatment from improper remarks that ought to be reported.

Our second concern is the compensation fund. The Board of Radiological Technicians supports the principle that victims of sexual abuse should receive the counselling and therapy which they need and that arrangements should be put in place to provide funds for such counselling and therapy. The board is of the view, however, that the source of the funding should be the government, not the members of the college.

The board appreciates that in this time of economic restraint, it is difficult for the government to find new funds to make available for such a compensation scheme. None the less, it is our strongly held view that sexual abuse is a societal problem and the responsibility to respond to the needs of the victims of sexual abuse is a societal responsibility, not the responsibility of the members of the college at large, who happen to be part of the same profession as the offender.

There does not appear to be any sound reason to impose the obligation to fund a compensation program on the colleges. The only explanation would appear to be that the government lacks the funds to create such a program. It is wrong for the determination of who is to fund the compensation program to be made on this basis.

Such a policy promotes a conflict of interest. The very body which is to determine whether one of its members has committed an act of professional misconduct is to determine whether the victim should be entitled to compensation at the cost of the college. Surely such a potential conflict of interest should be avoided.

Furthermore, to have the compensation fund created and supported by a special levy or assessment on the members of each college is to polarize the profession and to pit men against women and the professional associations against the colleges.

It is our recommendation to replace the compensation fund created by Bill 100 by a victim compensation fund, which would be a government-funded and government-



administered program. The board recommends that payment of all fines from disciplinary proceedings be made to such government fund.

Our third concern is the breach of confidential relationship between the patient and health professional. Bill 100 makes it possible that a report relating to sexual abuse of a particular patient could be made without the patient's consent. The only consent of a patient which is required is for the name of the patient to be included in the report.

In the board's opinion, it is a breach of the confidential relationship between the patient and a health professional that a report relating to sexual abuse of a particular patient could be made without the patient's consent. The board also feels that the patient's name and identity would eventually become known if the report proceeded to an investigation and disciplinary hearing. In the board's view, it is unacceptable to subject a patient who is the victim to examination and cross-examination in a discipline hearing against his or her wishes.

On page 8 of our submission we made three recommendations. The most important is that Bill 100 must clearly state whether an allegation of sexual abuse can proceed to a discipline hearing without the patient's consent.

The Board of Radiological Technicians has many additional specific concerns that are outlined in our written submission. For example, many unregulated therapists are not accountable to any public authority for their conduct. While we acknowledge the survivor's desire to choose their therapist, we are concerned that survivors will not be adequately protected from further sexual abuse.

The members of the Board of Radiological Technicians would like to thank you for taking this time to hear our submission.

**The Chair:** Thank you very much. I know there's much more in the brief than you've had time to present, but we appreciate the recommendations and other comments that you have made there. Any specific questions?

**Mr O'Connor:** On page 2 of your brief, you talked about the definition of sexual abuse with respect to behaviour or remarks should be amended so that—have you seen the amendments that had made some change? Section 3, section 1 of schedule 2 of the act is to be amended as follows. It's on page 2 of the bill. Did you see that amendment?

**Ms Morgan:** Yes, we have seen it.

**Mr O'Connor:** Okay. Did you feel the amendment addressed the concern that you had, or do you feel it should be changed to maybe add something like "to the appropriate service provider" or something of that nature?

**Ms Debbie Tarshis:** If I could respond to that, I think the proposed amendment—the element that is missing I think is captured in the word "inappropriate." So, yes, we are supportive of part of the definition, including the concept of inappropriate to the service provided.

I think the other comment would be that the board considered the other two words in the proposed amendment, which are "exploitative" and "seductive." The board's view is that those other two words do not capture

the subjective element of the effect on a patient as well as the word "demeaning" does.

**Mr O'Connor:** I would think it actually goes even a little bit further to be more inclusive to the concerns that a victim might have in trying to present real concerns that they may have. By removing that, are we losing some of the intent?

**2030**

**Ms Tarshis:** We didn't feel that one was. We also felt that the use of the word "inappropriate" was also very important in the context of this definition.

**The Chair:** May I ask you one question with respect to the fund, because it's an issue that has come up.

The first question may be of, I don't know whether it's principle or—I'll use that word anyway; you can disabuse me of the notion if I've used it incorrectly. Is there any point, though, in saying that if the members of the profession don't fund at least part of that, then there is a sense that somehow it's somebody else's responsibility; it's the government's or whatever?

I appreciate that your organization may be reasonably small in numbers, so I can see where there's just a practical problem in trying to determine how many cases there might be. But I just wonder, first of all on the question of principle, whether none the less there needs to be some direct involvement where in return for being a self-regulating college, that is part of the responsibility you assume as an individual who is part of that college. I just wonder if you'd address that in connection with this.

**Ms Tarshis:** Part of the board's recommendation, in acknowledging I think what you're expressing, is that all of the fines from disciplinary proceedings would be directed towards such a fund. So I think the board is quite aware of the need for the college to support a compensation fund. I think the difference on the matter of principle is whether or not the fund should be totally funded by the college and administered by the college.

**Ms Haeck:** Just as a quick point of information. I'm not sure if you were here for the previous presenters. I would assume that your college is relatively small.

**Ms Morgan:** It's 5,300.

**Ms Haeck:** The pharmacists were something like 8,140 across the province. You would have the ability to pool resources and thereby, shall we say, diminish the impact. I would suspect that you are also much like the group that was here just before you came, that in all likelihood you have never had—I say this advisedly and I stand to be corrected—but I would be interested to hear if in fact your board in its present incarnation has had to deal with a case of sexual abuse.

**Ms Morgan:** I think I'll let the registrar answer that.

**Ms Sharon Saberton:** One of the problems is in the act that we've been working with. In 1962, it didn't cover sexual abuse. It covered something called unprofessional conduct and hazardous use of radiation, so we were limited to those two topics. There may have been some complaints in the past that had some sexual abuse overtones, but any of the findings have been related to hazardous use of radiation.

**Ms Haeck:** Okay, but even sort of keeping that in mind, there is some history to this board. You probably have heard innuendo or allegations at some point.

**Ms Saberton:** Yes.

**Ms Haeck:** My own suspicion, having worked with the Regulated Health Professions Act and obviously generally looking at press clippings, is that your board has not exactly been high up in the headlines. What kind of history do you have, and just sort of general knowledge of concerns of the public around this issue?

**Ms Saberton:** We have had concerns expressed; we've had reports. Interestingly enough, as there's more publicity, there are more concerns. There are questions about: What are your standards of practice? Is this part of your standards of practice? There are certain cases that are under investigation right now. I would say there's more awareness of the issues around sexual abuse in the last three or four years than there ever was before.

**Ms Haeck:** I appreciate your comments. I think some of the survivors who are here are also very interested in your comments. Sort of looking at some of their concerns, I have to say personally I think the mandatory reporting will probably take care of a range of concerns both sides have, realizing that in all instances the name of the patient doesn't have to be used, but it would provide possibly for the board or their college in the end a means of determining what the situation is within the profession.

**The Chair:** Thank you very much for coming before the committee. I didn't realize just how numerous you were: 5,300.

**Ms Saberton:** Thank you.

#### ONTARIO NATUROPATHIC ASSOCIATION DRUGLESS THERAPY—NATUROPATHY

**The Chair:** If I could then call on the representative from the Drugless Therapy—Naturopathy organization.

**Dr Patricia J. Wales:** Good evening.

**The Chair:** Please go ahead, if you'd be good enough to introduce yourselves.

**Dr Wales:** My name is Patricia Wales. I will be speaking first, and then Jim Spring, who is chair of the regulatory board of the naturopathic profession, will speak. Then we could take questions after that.

**The Chair:** Just so we're clear, you're representing the Ontario Naturopathic Association and Dr Spring is the registrar?

**Dr James Spring:** I'm the chair of the board of directors of Drugless Therapy—Naturopathy.

**The Chair:** Fine. Thanks very much.

**Dr Wales:** I'll begin at the beginning again. My name is Patricia Wales. I am a practising naturopathic doctor, and I'm also the executive director of the Ontario Naturopathic Association, which represents the naturopathic doctors in Ontario. The mandate of the association is to maintain and promote the safe, effective and complete practice of naturopathic medicine within the regulated environment in Ontario.

In your brief that you've probably obtained by now,

the first page is an executive summary. The text of my report is there. We're attempting to make this as brief as possible at this time of the evening.

We appreciate the opportunity to present to the committee with respect to Bill 100 and the provisions it makes to deal with the issue of sexual abuse of patients by regulated health professionals.

The devastating effects of sexual abuse have become very visible in our society. Preventing the abuse, removing the offenders and helping survivors to heal are the key points.

The naturopathic profession is adamant that the issue of sexual abuse by health professionals must be effectively dealt with now. Our profession has adopted the zero tolerance policy, and we've formulated our action plan based on that premise.

Our profession is in full agreement with the provisions of Bill 100. The association, the board of directors of Drugless Therapy—Naturopathy and also the Canadian College of Naturopathic Medicine are jointly developing the policies, programs and procedures necessary to educate and regulate based on these standards.

All professions require due legal process to make zero tolerance an enforceable reality, and the naturopathic profession is no exception. Herein lies the problem. The naturopathic profession will not come under the provisions of the Regulated Health Professions Act or Bill 100 immediately. Our board will therefore not be legally equipped should an instance of sexual abuse by a member of our profession occur.

Our profession is committed to doing everything we can to make zero tolerance a reality. In the interim before the naturopathic profession completes the process required to move under the RHPA, we will in fact not be equipped to do so. Our commitment to public protection as a regulated profession will definitely be hampered.

For those of you who may not be familiar with the regulation of the naturopathic profession in Ontario, it may be helpful to provide you with a brief background on the profession and the effect of the RHPA and Bill 100 on the regulation of the profession.

Diagnosis, treatment and prevention of illness are the cornerstones of naturopathic medicine. The practice applies to substances and therapies to support and enhance the body's inherent healing processes. Naturopathic practice provides and brings together a real emphasis on prevention and health, which are the key words in progress in health care today, with its unique combination of clinical nutrition, botanical—herbal—medicine, homeopathy, manipulation, physical therapeutics, oriental medicine and acupuncture and lifestyle counselling and stress management.

To be eligible to practise in Ontario, naturopathic doctors must complete three years of pre-medical university and graduate from the dedicated four-year program in naturopathic medicine at an approved naturopathic college. The Canadian College of Naturopathic Medicine located here in Toronto is the only such institution in Canada and provides education in naturopathic medicine to students from across the country. Candidates must



meet strict board entrance requirements and then pass rigorous board examinations to be eligible to practise naturopathic medicine in Ontario.

#### 2040

The profession has been regulated in Ontario since 1925 under the Drugless Practitioners Act. However, the Health Professions Legislation Review included a recommendation in its 1986 report to discontinue regulation of the naturopathic profession.

Detailed submissions made by the profession to the Health Professions Legislation Review and to the Ministry of Health demonstrated that naturopathic medicine does indeed require regulation for public protection. The volume of letters and petitions to the ministry and the Legislature demonstrated that the public also recognized the need for regulation of the profession and demanded that it be retained.

The result was that the Minister of Health at that time, Elinor Caplan, decided to continue regulation under the Drugless Practitioners Act until new legislation for the profession was in place. After enactment of the new law, the naturopathic profession was scheduled to be the first to apply to the advisory council for admission into it. This agreement has since been honoured by Minister Gigantes and Minister Lankin.

The Ontario Naturopathic Association and the board of directors of Drugless Therapy—Naturopathy are preparing to begin that application process as soon as the RHPA is proclaimed and the application process is in place.

So, to review, the naturopathic profession remains under the Drugless Practitioners Act as the RHPA and Bill 100 come into effect. The association and the regulatory board have kept pace with the RHPA professions as this act has become ready to be proclaimed. Our board has been drafting RHPA regulations.

A joint committee of the association, of the regulatory board, of the Canadian College of Naturopathic Medicine and a representative of the group of victim-survivors has regularly met over the last 18 months and has prepared two reports regarding the issue of sexual abuse, with recommendations on an education program for prevention and recommendations to deal with any instances of sexual abuse under the provisions of Bill 100.

To summarize, the profession is in step and prepared to act on Bill 100. However, because we are not yet part of the RHPA and do not have an act under the RHPA for the profession, our regulatory board does not have the statutory power to put the policies we've been talking about today in place.

Our profession is ready to proceed. The advisory council is ready to proceed with our application also, as soon as the RHPA is proclaimed. We therefore submit to your committee the need for the timely movement of our RHPA application through the process to enable our profession to deal adequately with the provisions of Bill 100.

**Dr Spring:** As Dr Wales has stated, the naturopathic profession will be the sole regulated profession left in the Drugless Practitioners Act after proclamation of the RHPA. This means that the regulation of the naturopathic

profession in Ontario will be unaffected by Bill 100.

The board of directors of Drugless Therapy—Naturopathy is committed to the principles of zero tolerance and has formulated policy, (1) for adequate investigation of sexually related complaints, (2) to reduce retraumatizing the victims during the procedures, (3) to make the procedures fair for all parties, and (4) education policy and standards-of-practice policy for prevention of sexual abuse of patients.

It is our board's commitment to work to the best of our abilities to provide these services within the confines of the Drugless Practitioners Act, but it is our opinion that it will be deficient when you compare it with the protection that's under Bill 100 and the RHPA. Therefore, we feel it is in the best interests of public protection that the Ministry of Health, the health advisory council, the Ontario Naturopathic Association and the board of directors of Drugless Therapy—Naturopathy work together to facilitate the inclusion of the naturopathic profession in the RHPA as soon as possible after the proclamation.

Thank you for this opportunity for making this submission. Are there any questions?

**The Chair:** Thank you both for your joint submission. We'll begin the questioning with Ms Mathysen.

**Mrs Mathysen:** There's been some discussion, some debate, about a fund to provide for counselling of victims of sexual abuse. Some health professionals have indicated that they would like their own fund and others have indicated they would like to have a pooled fund. What would your preference be in terms of this fund?

**Mr Spring:** Our profession has 220 members, so the compensation aspect of Bill 100 was quite a concern for us, although in the last amendments you talked about the ability of the boards to get the money from the perpetrator by means of fines or whatever. As long as we can get the money from the perpetrator to pay back the college or our board for our expenses and for whatever therapy needs to take place, we would feel that that was adequate.

There are two things. First, you have a fine for the act if they're found guilty through disciplinary procedures. You fine them, and then of course it's up to the board to take their livelihood away from them as part of the disciplinary procedures. If you do that, then possibly there might not be any money left over to get from these people for payment of therapy. So that's a problem that we can see.

The only other thought we had on the subject was that the fines for sexual abuse proceedings go into a pool fund that would be paid directly to the victims. That would more than likely be administered by the government or some government agency, but the money would come from the fines, directly from the perpetrator, and go into a pool fund for the victims.

**The Chair:** What is the process? You note that for you it's important that the business of becoming part of the registered Health Disciplines Act get under way. You mentioned that this can't start until it is proclaimed. What is your understanding of what then happens, and approximately how long would your specific case be considered



before hopefully being accepted? What's the kind of time frame? I realize you're sort of the guinea pigs, being the first one on the block.

**Dr Wales:** The time frame isn't absolute as to its ending. Its beginning can happen very soon after proclamation, which we anticipate, from what we've heard, will be December or January. The advisory council has just released the updating on the criteria that all professions will be required to meet.

**The Chair:** Sorry. This is the advisory council of the Health Disciplines Act?

**Dr Wales:** Right, the Health Professions Regulatory Advisory Council. Now we are awaiting their drafting of the actual process, which I understand was supposed to be out sometime mid-November, so we're anticipating that soon.

We have had discussion with them already as to a possible time frame, and it would appear that it may be possible to start that application process in late spring. We're prepared to begin that as soon as it's ready.

Since we don't know exactly what the process will look like and we probably won't until we're participating in it, I can't answer that question. But I can say that we have met all the criteria. We were late in the process doing that, so we're not able to be a part of the RHPA at this date.

**Mr O'Connor:** We've had some discussion around the therapy and the funding of the therapy. We've heard from some of the practitioners who are of course from the regulated health professions who have come to the committee and told us that the only ones who should be used for any of the therapy should be them.

Of course you're not there, but in listening to what you've said, all the different types of therapeutic processes you go through with naturopathic medicine, I would almost think that you could be a therapy of choice that people may want to go to.

It is the case that we're hearing from the regulated professions saying that they're the only ones who should be recipients.

What are your thoughts on that? Can you see any benefit to the victims of different types of therapy?

2050

**Dr Wales:** I'll start and maybe Jim would have a follow-up. I think we do have a lot to offer in this area, but I think it needs to be in conjunction with people who are specifically trained to handle the traumatization of the effects of sexual abuse.

My brief experience with working with the committee that was dealing with this brought to my attention that I think all professionals need to have lot more education in recognizing the devastating effects of sexual abuse, whether it be something that is brought to the attention of the health professional or not, and in treatment of general conditions or specific conditions, it would appear to me obvious that we need a team approach and I think we do have a lot to offer to that approach.

**The Chair:** Thank you again very much for coming before the committee at this late hour. We appreciate it.

#### COLLEGE OF OPTOMETRISTS OF ONTARIO

**The Chair:** If I could then call upon the representatives from the College of Optometrists of Ontario, if you would come forward. Welcome to the committee.

**Dr Martin McDowell:** I've given Mr Arnott our presentation and I think that has been distributed.

**The Chair:** Yes, we have copies of it. Thank you.

**Dr McDowell:** Great. I'd like to introduce myself. My name is Dr Martin McDowell and I'm an assistant registrar with the College of Optometrists of Ontario. I have with me tonight Dr Irving Baker who is the registrar of the College of Optometrists of Ontario. I must add that Dr Baker is the longest-serving registrar of any of the colleges in Ontario so he comes with a lot of experience and background.

**The Chair:** A double welcome then. He's probably been before these committees many times.

**Dr Irving Baker:** I'm a survivor.

**Dr McDowell:** The College of Optometrists of Ontario is in fact one of five colleges described under the Health Disciplines Act. We have a history. We regulate 885 practising optometrists in this province, so I suppose we are one of the smaller colleges and have particular concerns, perhaps as a result of that smallness.

Perhaps also we have a particular closeness to certain issues because of that smallness and I think we can talk to some of the issues of Bill 100 because of experience and because of our intimacy with our practitioner base. Just as a matter of note, we've provided 2,300,000 OHIP-insured diagnostic eye and vision care services last year. So although we're small in numbers, we work hard.

We're here because we are an experienced self-regulating profession and we believe that on some we've managed to carry out our mandate with some degree of alacrity, that we have dealt with all of the matters colleges deal with—licensing, complaints, quality and discipline—for a number of years and we believe we've done so in a reasonably fair and effective way, including those matters of professional misconduct. We do have experience with practitioners who have abused their patients.

On the matter of sexual abuse, we have come to understand abuse of patients as a significant problem in the health care system in Ontario, but it is also, and must be recognized as, a significant problem within society and we want to go on record as saying that. No health profession can claim immunity from abuse of patients. We recognize that, but we also recognize that it comes about as a result of some of the power differentials that may exist between practitioners and patients and that those power differentials exist outside of the health professions as well.

We also say that sexual abuse of patients is never acceptable and we have dealt with those matters of sexual abuse that have appeared before us in ways that we have deemed to be effective. There have been issues in all of the health professions, we believe, with accessibility to the colleges on behalf of victims. We perhaps have not done a good enough job in making our regulatory services known to the public and available to the public

but, none the less, where those matters have arisen, we believe we have dealt with them.

This college was one of the members of the coalition of colleges that presented to you early last week. Fundamentally we agree with and indeed signed the document and want to reiterate our support for that document that was presented to you. We also welcome this individual opportunity to speak to you about Bill 100 itself.

We as a college want to express our sincere concerns regarding those individuals who are abused by non-health practitioners in this province or by non-regulated health practitioners. We believe this is as much an issue perhaps for this committee to be considering, and certainly we would suggest that Bill 100 does nothing to address these very real injustices in our society.

About mandatory reporting we have no particular problems. We're familiar with it. Optometrists have for many years been required to mandatorily report a variety of things under the Highway Traffic Act, under the Aeronautics Act and under the Child and Family Services Act. We're familiar with that and as a college we understand that this can be administered in an effective way and we believe mandatory reporting of sexual abuse is in fact in the interests of the public of Ontario.

We do have a major concern about funding, and I think you can understand that, having probably heard that from a number of presentations that have come before you. Perhaps we can shed a little light on it from a slightly different perspective.

At the bottom of page 4, we make a comment. At no time has it ever been recognized that colleges of the professions are capable or in a position to adjudicate civil or criminal matters or matters of compensation to an individual based on professional or practitioner malpractice, and we believe that holds true for compensation as it relates to treatment or for counselling for survivors of sexual abuse. That is not to say it is unnecessary. We believe fundamentally it is. We have seen some of the pain and discomfort that survivors encounter and we recognize that these individuals are in dire need of assistance.

At the same time, on a matter of principle, we have to recognize that we believe such a funding proposal as Bill 100 puts forward will place our college, and I believe all of the colleges, in a position of conflict of interest. It will be incredibly difficult for discipline panels comprised of both public members and professional members to look at cases in an unjaudiced way with issues of funding that potentially could place colleges such as our own in financial difficulty, to put it mildly, when we have such a small number.

We are concerned about this. We believe it's an issue for our college just from a purely administrative standpoint, but also from a matter of principle, that is, of conflict of interest.

Who should pay for funding then? Where should it come from? We believe it should be indeed from the perpetrators, those who abuse, so we would support a funding provision that would specify fines for sexual abuse that could be levied by discipline panels, but that

those fines would be directed towards an independent body that would then go on to administer the funds to those individuals who so desperately require them.

On the matter of reporting of incompetence and incapacity, we understand that it is the ministry's proposal to modify Bill 100 to remove mandatory reporting of incompetence and incapacity, and we would certainly support that.

About the definition of "sexual abuse," once again you may have heard this from other presenters, but we reiterate what may have been said about the definition. The people who will be using this definition are going to be practitioners and public members. In the sense of knowing what to report, I can tell you that this would be a very confusing thing, to know what to report as a practitioner, if the definition of "sexual abuse" is subjective. We believe very strongly that the proposal put forward by the coalition of colleges is an acceptable one, is a workable one, is one that can be well understood by individual practitioners, and we would strongly support that.

## 2100

Secondly, we also believe that discipline panels, in looking at what sexual abuse is, must also have a very clear and unsubjective definition of sexual abuse.

The penalty for sexual abuse carries with it an extraordinarily strong impact on the individual who is charged with abuse. Let it be said that the removal of one's licence, delicensure, as required by Bill 100, is tantamount to removal, permanently, from the profession. After five years there is no right to relicensure. One will come back to a college and request licensure again, as anyone who is requesting licensure. Simply, the educational requirements will have passed this person by. So we need to know, as discipline panels, precisely what it is in order to fairly adjudicate the law. That is not an attempt to protect practitioners; it is just simply, in fairness, that people must know what they are administering, people must know what they are charged with and must know what the penalties for those behaviours are.

We strongly support the coalition's position which adds a fourth qualification, as it's stated at the bottom of page 7: "For the purposes of subsection (3), 'sexual nature' does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided." We believe that practitioners and panels can work with that definition.

In conclusion, then, we respect and appreciate what the minister and the Ministry of Health have done in bringing forward Bill 100 to prevent and deal with difficult and painful realities for patients. We believe that, with modifications, Bill 100 could be effective and a fair tool for utilization by this college and other colleges in protecting the public. But we believe that Bill 100, and specifically as it relates to funding, should not be constructed to place the colleges in a conflict of interest.

Thank you. Have you questions?

**The Chair:** Thank you very much for your submission, and particularly for the recommendations that you make in it.



**Ms Haeck:** A quick question: The issue of pooling was raised by a group last week, and I have to apologize to that group. I have successfully forgotten which organization it was but it did flag it for me. It is permissive, within the legislation, for a range of colleges to actually come together and pool these resources. Have you contemplated doing this to deal with some of the issues that you raise?

With 885 members, I understand that would be a concern, but I would also ask the question, have you had any cases of impropriety along these lines?

**Dr McDowell:** You've asked two questions, so let's talk about the pooling first of all. Our submission suggests, and I reiterate, that we would be in support of a third party, if you will, or a separate or standalone entity or body that would administer funding.

Certainly we agree that those people who perpetrate sexual abuse ought to be fined, in addition to any other requirement made of them professionally, and we believe that funding ought to be directed towards such an independent body.

In that sense we would be in support of pooling but we do not feel that it is a role or in fact is most effective or could even be done without a significant conflict of interest for colleges to administer such a fund.

**Ms Haeck:** There is a variety of views on that, but I understand your point.

**Dr McDowell:** Your second question related to, have we had to deal with matters of sexual abuse by our members, the answer to that is yes. The penalties have varied, frankly, as has, we believe, the extent of the involvements with patients. Frankly, if Bill 100 were in place today, it would alter some of the decisions that were brought forward by our discipline panels.

**Ms Haeck:** I would suspect that may be true for a number of them—

**Dr McDowell:** Yes, absolutely.

**Ms Haeck:** —that have been concluded over a number of years. Thank you very much for your submission.

**Mr O'Connor:** Mr McDowell, on page 7 of your brief, halfway through page 7, in particular there are suggestions around (b) and (c).

The bill has an amendment before us around (c) which goes a little bit further than the (c) you have on your page. It includes beyond the word "patient" the words "that are demeaning, seductive or exploitative," which further clarify exactly what "sexual nature" can mean.

You've gone on in your proposed amendment to further clarify. Have you seen this, and what are your thoughts on that amendment to try to clarify exactly what "sexual nature" means?

**Dr McDowell:** First of all, we have seen that, yes, and we've considered it. We don't think it clarifies; in fact, we think it maybe muddies it a little bit. We believe those terms are more subjective than we would like to see. We think there's a diversity of opinion about what is demeaning, about what is—I'm sorry, I forget the other two words.

**Mr O'Connor:** Demeaning, seductive and exploitative.

**Dr McDowell:** For the purposes of those individuals who sit day by day and practise and may come in contact with patients who describe to them events that they deem to be seductive or demeaning, we feel it would be a much easier yardstick for a practitioner to say, "Is what occurred appropriate to what that professional was intending to do with the patient?"—that is, care for their health.

When we entertain some of the wording that you've suggested or that is proposed, we believe that's a very difficult thing for a practitioner, to make that kind of decision. We believe it's easier to come down to a decision about what's appropriate to the service being provided.

**Mr O'Connor:** The intent of the legislation is to keep in mind the victim. To each victim, what they may see or feel to be a degree of sexual assault is reality to that person, to that individual, to that victim. So it's pretty hard to gauge exactly what is the degree that a person has been assaulted, whether it is a remark to one person or an actual demeaning comment, whatever.

Would you be comfortable with the added words through the proposed amendment, including perhaps some of what you say towards "appropriate to the service provided" or "the clinical service provided," given your concerns and given that we're trying to view this as well from the victim's standpoint?

**Dr McDowell:** I think combining definitions would probably further muddy it, because what it might suggest is that there are times when demeaning contact is appropriate, if you can capture that inflection. So I think you have a decision perhaps to go one way or the other on this. You've asked our opinion; our opinion is that we would suggest a definition that says "appropriate to the service provided." It's an easier yardstick for our members and it's an easier yardstick—when I say "easier," I mean a more defined and a more realistic yardstick—we believe, for our discipline panels.

**The Chair:** We will give the final word to your colleague.

**Dr Baker:** I'm not sure it's the final word, but I think that some of our attitude could in fact be changed with respect to this (c), because in the consolidated report that we have, there is reference to the fact that clause 1(3)(c) might be handled differently than (a) and (b). That is, (c) would be handled as possible assessment for remediation, as opposed to an automatic revocation.

We've heard nothing about this, by the way. We spent a considerable amount of time playing with the words, because we have difficulty with this. But if in fact (c) is going to be viewed as a lesser offence potentially, where in fact the discipline committee can exercise some judgement as to the nature of the penalty, then some of the other wording might be acceptable and appropriate. But we have no guidance on this. We have no information, other than the fact that it's been flagged. If somebody could tell us what they were thinking about when they were referring to (3)(c), that would be helpful in



giving a more considered response to the earlier question.

**The Chair:** Perhaps I'll ask the parliamentary assistant if he can—

**Mr Wessenger:** I'm going to have to ask legal counsel to perhaps clarify.

2110

**Ms Christine Henderson:** Thank you for your comments around the coalition definition and the clarification that you seek, that you believe would more expressly define "sexual nature" as being something that was not of a clinical nature and appropriate to the service provided. A number of other groups have also made that similar submission.

In relation to "remarks or behaviour of a sexual nature," the government has set forward its position that there will be a motion tabled that will provide more flexibility to colleges. In fact, it wouldn't be a matter that would necessarily have to go to the discipline route at all. In fact, in the appropriate case, the college could make a determination that it was an appropriate case—1(3)(c), sexual abuse, only words or gestures of a sexual nature—that would be best dealt with with some assessment and a special education program, whatever was needed for that particular individual.

Because as Dr Gary Schoener indicated last fall, colleges need flexibility to have options available other than the disciplinary route, because as he said, many of these kinds of incidents are not dealt with appropriately at the discipline level. Rather, maybe there are some communication skills required, maybe an upgrading around the boundaries of the patient-practitioner relationship etc. That's what is going to be dealt with so that it wouldn't get to the disciplinary stage. The executive committee likely would have the authority to refer this on for an assessment.

**Dr Baker:** When will we see this?

**Ms Christine Henderson:** I'm waiting to get some direction on that.

**Dr Baker:** That would relieve a lot of our problems with that definition if there was the opportunity to use some discretion. This gets to be a very difficult matter with these things.

Perhaps just to end in a very short way, let me tell you what kind of thing comes to our attention which is very difficult to handle, because you don't want to dismiss it. You have someone call who obviously is upset, and what they really want to know is, what is the process? They feel that they have been subjected to something by a practitioner that in fact is not appropriate.

I'm learning a great deal as I go through this as to how to handle these kinds of situations, and incidentally, they are popping up more frequently because of the publicity and the fact that the thing is out of the box, if you will.

You finally get around to saying, "What in fact is troubling you?" What came out—and this is an actual, almost verbatim report. This lady said to me that she had her eyes examined by an optometrist, he asked a history and so on, and he was going to do an ophthalmoscopic examination, which is an instrument that you look inside the eye with and you get very close. Now when he got

very close, she said that he started to breathe heavily, and she assumed this to be the beginning of a come-on in this kind of situation.

You can smile and you can do whatever you like with this, but you don't know whether it's that superficial in the sense that here's a person who's triggered, for some reason or another, to something that really is innocuous or whether this is the beginning of something. So you have to do a lot of listening in order to find out what in fact happened.

The nature of the complaint was simply the heavy breathing. That's difficult, and you can handle it sort of superficially and you could almost say maybe he has asthma; I don't really know. But you can't say that. The fact is that this is where you get into this very grey area where people will say this.

A normal history, for example, particularly with contact lens practitioners who may be considering contact lens work, they may very well ask a female patient whether or not she's taking birth control pills because it can have an effect. The point is that this is a legitimate question in that clinical setting but may not necessarily be viewed that way by the lady.

So we have to have some kind of a situation which is directive at one portion to our members because we're eventually going to have to draw boundaries as to how far you can go and what you should do in certain circumstances, and we will be doing that. But that area is a touchy area.

The first two areas are not difficult at all. They either happened or they didn't and they don't require any subjective kind of evaluation. They either happened or they didn't happen and you can describe that. But as soon as you get into this question of touching or of remarks or comments, then you're into a very grey area and it's very difficult.

We get all kinds—not all kinds of calls but we get enough calls. For example, we had a call today from somebody who said, "Is it normal for a person going to have their eyes examined to have the practitioner ask them to take off their blouse so they can listen to their heart?" As it happened, it wasn't an optometrist fortunately, but those are the kinds of question that we're now beginning to get on a fairly regular basis and those need to be handled, but surely a lot of them don't have to go to discipline. That's the point.

**The Chair:** Thank you very much for providing an outline of what you are meeting in the day-to-day sense. Parliamentary Assistant, is there anything else that you wanted to add to that?

**Mr Wessenger:** My policy assistant might want to add something.

**Ms Ella Schwartz:** I just wanted to add something to what Christine was saying. She was talking about the—

**The Chair:** Could you identify yourself?

**Ms Schwartz:** I'm sorry. I'm Ella Schwartz from professional relations branch. I'm the policy analyst.

**Dr Baker:** She's well known to us, by the way.

**Ms Schwartz:** I just wanted to add something.

Christine was saying about the discretion for how you would deal with reports or maybe even complaints of behaviour and remarks and they wouldn't always necessarily go to discipline, but of course, even if they did go to discipline, there's a wide discretion of penalty of how to deal with them.

**Dr Baker:** Absolutely, except that there's an awful difference in cost in handling them one way or handling them the other.

**Ms Schwartz:** Yes.

**Dr Baker:** It's very upsetting not only to the persons who have been victimized or feel they've been victimized, but it's traumatic as far as the practitioner is concerned. Going to discipline is not an easy matter from a practitioner point of view. I think there should be at least some sensitivity in that area.

**Ms Schwartz:** Yes.

**The Chair:** Thank you once again for coming before the committee.

2120

ALEXANDER FRANKLIN

**The Chair:** If I could then call on Dr Alexander Franklin. Welcome to the committee, Dr Franklin. The hour is late, so please go ahead.

**Dr Alexander Franklin:** Mr Chairman, members of the committee, Bill 100 will have an effect on Ontario's credit rating, its public relations worldwide and the practice of the art and science of medicine.

There are advantages and disadvantages to the bill. The writing into Ontario law of a strict legal doctrine regarding sexual behaviour between doctor and patient has long been in use by the General Medical Council in the United Kingdom. The legal principle is that one may make a patient of one's mistress, the sexual partner in today's terms, but never a mistress out of a patient. In the UK, removal of licence has been the penalty.

Another advantage is the restoration of the chaperon as a requirement for the examination of a patient of both sexes. The Ontario College of Physicians and Surgeons has regularly published the need for the presence of a chaperon. Common practice over the past 20 years has been to ignore this advice. Why? Mainly because of the expense of employing a professional person in the examination room and also because the majority of patients prefer verbal and physical privacy.

Doctors will now work to the college rule or face loss of their medical livelihood if a patient complains of one of the eight proscribed acts in section 11.

Restoration of formal professional behaviour between physician and patient: In the past 20 years, there has been a tendency to use less formal behaviour, language and dress, especially the use of first names. This has led to a state of familiarity breeding contempt.

However, Bill 100, which will severely punish both visual and verbal sexual behaviour, will force physicians to return to the formal relationship of the 1950s. A doctor could be ruined with the wink of an eye. Doctors' dress has altered since the 1970s. Some male physicians change from wearing business dress or a long white coat to a

relaxed style with open shirt, long hair and sandals.

Disadvantages of Bill 100: It implies a state of sexual infantilism in Ontario medical practitioners of both sexes being unable to control their normal libidinous impulses in the presence of a physically attractive patient of the same or opposite sex.

Bill 100 will make Ontario a world laughingstock, adding physicians to the Ontario judiciary and religiously sexually incontinent. It will further diminish trust in the maturity of many of its leading citizens. Character is a factor in determining the credibility of a loan applicant. Bill 100 implies that 17,000 of Ontario's more educated citizens, with at least 10 years of post-secondary education, need laws to make them behave in a professionally detached manner due, it would appear, to impoverished self-control.

Cost of chaperons: As it is not practical or even advisable to insist that a patient bring a chaperon at each visit, physicians will have to hire and hospitals provide extra staff at least at the registered nurse assistant level. I suggest that this will cost practising physicians at least \$20,000 a year even at minimum wage. Who is to pay for this, government or patients?

One way of financing this extra fiscal burden would be for government to pay the wages directly, making the chaperon a contract civil servant. Chaperons could be seconded from a central pool. Patients might object at first but, with government propaganda, the presence of a chaperon would become the accepted norm.

The behavioural change of physicians into a more formal mode will go against the present trend of regarding the physician as a pal. Patients might think this represents a more authoritarian, less friendly, less caring attitude. However, a slip of the tongue or a careless glance could lead to economic disaster for the physician and the physician's family. Each word would have to be carefully weighed for any trait of sexuality.

In practical terms, Ontario medicine would return to the Victorian era. Conversations with patients would be limited to words of emotional neutrality, as described by the greatest of all Canadian physicians, Sir William Osler, as *aequanimitas*. We would have a style of medicine practised in societies with strict sexual taboos, such as those with fundamentalist religions.

There will also be an increased emotional distance between physicians and other health workers. Bill 100 encourages informers to report any perceived misconduct. The democratic movement to break down the master-servant relationship with, for example, communal eating areas in hospitals and the elimination of the officer-style doctors' mess will, I believe, come to an end. The health care community will go back to the military separation of officers, sergeants and other ranks.

As there is no statute of limitation for medical sexual misconduct, I suggest that physicians will use recording devices to monitor their practice. At present there is a trend among surgeons to videotape patients' consent to operation. Audio-visual records would have to be stored for the doctor's lifetime: at whose expense?

Ontario is deeply in debt. Now is the time for econ-



omic teamwork to save our relatively high standard of living and democratic attitudes. Bill 100 will turn health workers against one another as informers, and if the citizens of Ontario wish this to happen, they must be prepared for the consequences. This, Mr Chairman, concludes my presentation.

**The Chair:** Thank you very much for your presentation.

**Mrs Mathysen:** I've listened to people who have been victims and it would seem that victimization has undermined the health profession in Ontario. I'm wondering if this bill would not restore that faith in health professionals rather than further undermine it.

**Dr Franklin:** Mr Chairman, I believe not.

**Mrs Mathysen:** Why?

**Dr Franklin:** For the reasons I've just given, Mr Chair.

**Mrs Mathysen:** I came from the teaching profession and the reality was that teachers had to become more sensitive to children and so we simply took steps. For example, a male teacher would not be in a room alone with a female student if that made her feel uncomfortable. Would it not simply make sense that health care providers would be sensitive and meet the needs of their patients in the same way, being alert to potential problems and simply accepting them for the good of the profession and the patient?

**Dr Franklin:** Mr Chairman, I believe the medical profession in Ontario is doing an excellent job at the moment and does not require Bill 100.

2130

**Ms Haeck:** Dr Alexander—

**Dr Franklin:** Excuse me, my last name is Franklin.

**Ms Haeck:** Oh, I'm sorry. What did I say?

**The Chair:** Dr Franklin's first name.

**Ms Haeck:** Oh, I'm sorry. I do apologize. That was by no means said intentionally.

I am somewhat concerned about your comment where you're saying the medical profession is doing extremely well around this particular issue. In fact we had an article in the paper last Friday and we had the survivor of that encounter with a particular medical practitioner presenting to us today, and I am aware of cases in my own riding where in fact doctors have encountered problems around sexual abuse.

There are a number of medical practitioners, doctors being one, psychiatrists, dentists—those are the three that come quickly to mind—who have encountered some serious problems with sexual abuse of patients. Personally, speaking only for myself, I think Bill 100 goes a long way to actually assisting the victims, but also I think sets a standard other countries in the world can look to for an example to address their own medical professions. I'd be interested in your comments.

**Dr Franklin:** Mr Chairman, the last speaker mentioned sexually abusive patients. Did she really mean that?

**Ms Haeck:** No, I didn't. We've had patients here who have been sexually abused. They are survivors; they are

victims. I'm aware of patients who have been treated by doctors, a range of medical practitioners, in my own riding, and your comment saying that you felt the Ontario medical practitioners were handling this situation well is one that I do not necessarily see as being accurate. That's my view. I was wondering if you could comment on that.

**Dr Franklin:** Mr Chairman, the last speaker has opinions which I respect, but I think she brought up—it may have been a Freudian slip—that in fact there are sexually abusive patients, and this has not been brought up in the bill. Patients perhaps should be treated equally as their physicians.

**Ms Haeck:** Would you not believe that a doctor, should he or she wish to sue a patient, probably has more wherewithal to do that than any patient I've encountered so far?

**Dr Franklin:** As far as I'm aware, the legal aid system in the province is excellent.

**Ms Haeck:** We could get into a debate, but I won't go any further at this moment, Mr Chair.

**The Chair:** Dr Franklin, thank you for coming before the committee this evening.

**Dr Franklin:** Thank you very much.

#### SOCIETY OF INDEPENDENT COMMUNITY PHARMACISTS OF ONTARIO

**The Chair:** I'll then call on our last presenter of the evening, the representatives from the Society of Independent Community Pharmacists of Ontario. Gentlemen, you've been waiting patiently and we thank you for that. Please introduce yourselves and go ahead with your presentation.

**Mr Jerry Taciuk:** My name is Jerry Taciuk and this is Andrew Musial. I was a founding director of the society back 10 years ago and Andrew is president. I'm now on the Etobicoke board of health.

I thank you for the opportunity to come here. There is an advantage to coming late. Then everybody can leave late with us. I remember this room back in 1985 for Bills 54 and 55, and I swore that this room was bigger, but it wasn't. We spent a lot of time in here when Murray Elston was on board.

I'm sorry we don't have a presentation. Sometimes it's better not to put things in writing that you don't want to come back at you.

**The Chair:** That's all right. We do have Hansard.

**Mr Taciuk:** Yes, I know that.

We're starting with the presumption that the legislation is absolutely perfect, nothing wrong with it, where do we go from there? That's the point.

I have done work at the College of Physicians and Surgeons, the law society, the College of Pharmacists and also the Health Disciplines Board. I love playing in what they call administrative law, and the legal counsel probably know the Canadian Journal of Administrative Law and Practice.

The problem is, we're coming up with a beautiful piece of legislation, but the concern is on this enforcement of the legislation. It's a quasi-judicial tribunal that is doing the enforcement. In the case of the pharmacy,



which we're both in, the members of the committee are chosen by the college and then you have lay members chosen by the government. As it says in this administrative, "The public will have confidence in the tribunal if they have confidence that they are not seen as the dumping ground of the political system." That's a problem.

But in our case there's a bigger problem. Pharmacy is a unique profession where we're in commercial as well as professional. In the case of pharmacy, you have some chains that have 300 stores across Ontario. If they have one member on the discipline committee and it just so happens that your store is a store they like in St Catharines—I'm giving an assumption—it makes it very difficult because it's not totally independent like it would be in medicine, dentistry or law. They don't own 150 dental offices. So it's a very serious problem.

With respect to health legislation, the question must be answered, is the tribunal operating under administrative law? There are no rules of evidence there. That brings a big problem if there are no rules of evidence.

For example, I have here from the College of Physicians and Surgeons a review to the Health Disciplines Board. I have filed something there and I am number 300 on the list for a hearing. Do you know how long that's going to take? A year. Not only; they breached rules of evidence. You're dealing with the complaint of the doctor against me, against what I said about him. They've got no jurisdiction. Now I've got to wait a year to find this out.

This is a serious matter because the members of the committee do not have the knowledge, and now we're talking sexual abuse. I shudder in pharmacy. If you look at the situation and you say, okay, they don't adhere to the rules of evidence; they don't have to—the selective disclosure of documents, I asked for disclosure and they said the Health Disciplines Board will review what they will let you have. Amazing. I can go to the courts and get it all. I can't get it there.

Third, these are political appointments. Fourth, they're not trained in the law. The irony is that I was at two hearings at the Health Disciplines Board where they have a lawyer who is there acting as a consultant to the board. Actually, he is the bus driver, because all the people in the room don't have any experience in law, so he drives the bus. The irony is that it's already been written up in the Toronto Star on two cases. One of them was mine that we didn't bring forward back a year ago. I wasn't even involved so I just love—what do you call that? Act as an agent for people.

One other point: There's no oath of office. Can you imagine somebody handling a hearing for you being charged with sexual abuse and the guy didn't even take an oath of office? That's scary.

Are they competent? This is only a small eye opener. I've got lots in this textbook on administrative law. How would you feel, as a member here, being charged with sexual abuse with all of these factors—I can give you more—and know that you're going to have to go in front of this committee? Would you rather go there or in front of the judiciary? Mr Musial will carry that part for me.

**Mr Andrew Musial:** We have an offence or any breach of the law, whether federal or provincial, to which a penal sanction is attached. The federal Parliament can create the laws under its criminal power in section 91.27 of the Constitution and the ancillary enforcement measures, which is the "peace, order and good government" clause.

The provinces also have the ability to create certain offences under provincial legislation, that is, "Property and civil rights" in section 92.13. Private law of property and contracts, torts and many others and their derivatives are covered in this section. Then there's the second section where the province can bring forward legislation, "Generally all matters of a merely local or private nature in the province," which is section 92.16.

Presently, sexual assault, of which I believe this bill is a mirror image, is covered under the Criminal Code. Our position is that I don't think the province has the statutory authority to bring forward the bill as it is. The bill may be effective after somebody has been convicted of sexual assault but not before. I think what the legislation wants is really to remove a practitioner who is guilty of a sexual offence, and we agree with that. We shouldn't have people practising who don't have the moral standards to practise. But we do find a problem here where we have now parallel legislation to that in the Criminal Code.

#### 2140

Whether that issue has been looked at by the province—because I dealt with another one, and that was the licensing of boats. At that time I went through Minister Ziemba, who's in my constituency. We addressed the issue. Howard Hampton did, after months of searching the precedents, come back and say, "No, we cannot have boating legislation because the Constitution doesn't allow it."

What I'm saying is, does the Constitution allow the Legislature of this province to bring in sexual abuse legislation, which is of a criminal nature, rather than dealing with an amendment to the federal Criminal Code or perhaps an amendment which ought to be brought in to take care of a practitioner who is convicted of a sexual abuse case?

**The Chair:** Thank you. Perhaps we can try to just deal with a few of the questions you've raised in the course of your presentation. I ask the parliamentary assistant or legal counsel to respond.

**Mr Wessenger:** I think it should be clear that the colleges would be subject to the Statutory Powers Procedure Act, as are all administrative tribunals, so they would be no different, for instance, with respect to the tribunal under the RHPA. For instance, it will say the municipal board or the Labour Relations Board. I hope I'm correct in that regard.

**Interjection:** Many tribunals.

**Mr Musial:** They don't deal with criminal matters; they deal with matters of a summary conviction nature. It's not a criminal offence. We're dealing with a criminal offence, which is sexual abuse of a patient, which is sexual assault. How do you differentiate that?

**Mr Wessenger:** I would disagree with you. These are not criminal matters.

**Mr Musial:** Sexual abuse is not a criminal matter?

**Mr Wessenger:** They're matters determining the fitness to practise a profession.

**Mr Musial:** No, that's not true. The Criminal Code specifically addresses criminal assault. If you look at your sections in the act, they deal specifically with the sexual nature of the crime. How does the province take jurisdiction in a criminal—that's what we want answered.

**Mr Taciuk:** I have the act right here. Under section 271(1), "Every one who commits a sexual assault is guilty of (a) an indictable offence and is liable to imprisonment for a term not exceeding ten years or (b) an offence punishable on summary conviction."

You brought up a very important point that with respect to using the administrative tribunals for a sexual matter which is life-threatening to professionals—they lose their licence—you look at the appeal mechanism. In the health professions it's the Health Disciplines Board: 300 cases in line before when I've tried to put an appeal on a complaint.

They said, "Oh, the reason is, once we get the new legislation, then everything's going to move smoothly." There are two reasons you've got 300 people backlogged: The public is fed up. They're not getting proper treatment, and the colleges are not handling it properly so they appeal to the board.

Once the new legislation comes through, it's not going to change things. It concerns me that you're having a sexual abuse thing and you have no appeal mechanism. Once you hit the Health Disciplines Board, then you go for—what review is that?

**Mr Musial:** We'd have a judicial review on a point of law—

**Mr Taciuk:** —a judicial review on procedure, on points of law only.

**Mr Musial:** —not on whether you're innocent or

guilty. So there's no mechanism, and the regulatory mechanism—if I may add, there's another problem and I've noticed it over the years, that more and more of the, I would say, onus of the legislation is going towards regulations.

I believe Christel is the Chair of the standing committee on regulations.

**Ms Haeck:** Regulations and private bills.

**Mr Musial:** That's right. I had a conversation with you prior to that in looking at an appeal of a regulation. There is none. The only way you can appeal any regulation—there's no input, no democratic way of dealing with it in committees and so forth. The only way you can go is through a criminal court. I think what this Legislature is doing is giving the powers of the members of the Legislature to the bureaucracy, and that's becoming very scary.

As you're leaving everything to the regulatory mechanism, who does the accountability on whether or not these things are properly done and whether the public has any input into a regulation? These are problems. I think it's nice to hand it over to the bureaucracy to do because it's an easy way, but in effect it's not a democratic way.

**The Chair:** Thank you. I think you've raised some interesting issues that I suppose one could say we'll sleep on and try to deal with as we continue with the bill. Thank you again for coming before the committee.

**Mr Taciuk:** We probably will put a brief in but we've got so many things right now.

**Mr Musial:** We have the tobacco issue, we met with the Minister of Health; we had other issues. I'm sorry, but we're a small organization and we don't have the resources to do it.

**The Chair:** That's quite all right. We appreciate your coming before us.

With that, members of the committee, we stand adjourned until 3:30 tomorrow.

The committee adjourned at 2146.







*Continued from overleaf*

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York North/-Nord L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry (Durham-York ND)**

**\*O'Neill, Yvonne (Ottawa-Rideau L)**

**\*Owens, Stephen (Scarborough Centre ND)**

**\*Rizzo, Tony (Oakwood ND)**

**\*Wilson, Jim (Simcoe West/-Ouest PC)**

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Haeck, Christel (St Catharines-Brock ND) for Ms Carter

Harrington, Margaret H. (Niagara Falls ND) for Mr Owens

Haslam, Karen (Perth ND) for Mr Hope

Mathysen, Irene (Middlesex ND) for Mr Hope

Wessenger, Paul (Simcoe Centre ND) for Mr Martin

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Henderson, Christine, legal counsel

Schwartz, Ella, policy analyst, professional relations branch

Wessenger, Paul, parliamentary assistant to the minister

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Gardner, Dr Bob, assistant director, Legislative Research Service

Swift, Susan, research officer, Legislative Research Service

# CONTENTS

Monday 29 November 1993

<b>Regulated Health Professions Amendment Act, 1993, Bill 100, <i>Mrs Grier / Loi de 1993 modifiant la Loi sur les professions de la santé réglementées, projet de loi 100, M<sup>me</sup> Grier</i></b>	S-559
Canadian Bar Association—Ontario	S-559
Tony Caldwell, member, executive committee, health law section	
Linda Bohnen, member, executive committee, health law section	
Joan MacDonald, member, feminist legal analysis committee	
College of Nurses of Ontario	S-562
Pat Mandy, council president	
Elisabeth Scarff, director, policy analysis and development	
Spiricoasis	S-564
Alex Perlman, president	
Ontario Medical Association, Section on Psychiatry	S-566
Dr Patrick Conlon, chairman	
Dr Judith Hamilton, executive member	
Stasha Novak	S-570
Med-Aware Publications, Patient Advocacy Issues	S-571
Elizabeth Rankin, president	
Sharon Danley	S-575
Ontario Psychiatric Association	S-577
Dr Joan E. Bishop, president-elect	
Dr Brian Hoffman, chair, legislative review committee	
I Know Network Ontario Cosmetic Surgery Health Information Inc	S-580
Kathleen Lumsden, president and co-founder	
Elayne St Pierre, member	
Barbara Kerr, member	
Feminist Working Group on the Criminal (In)justice System	S-581
Susan Bazilli, coordinator	
Ontario Massage Therapist Association	S-584
John Sanderson, executive director	
Ontario College of Pharmacists	S-586
Madeline Monaghan, president	
Christina Langlois, manager, patient relations	
Board of Radiological Technicians	S-589
Janet Morgan, past-chair	
Debbie Tarshis, legal counsel	
Sharon Saberton, registrar	
Ontario Naturopathic Association; Drugless Therapy—Naturopathy	S-591
Dr Patricia Wales, executive director	
Dr James Spring, board chairman	
College of Optometrists of Ontario	S-593
Dr Martin McDowell, assistant registrar	
Dr Irving Baker, registrar	
Alexander Franklin	S-597
Society of Independent Community Pharmacists of Ontario	S-598
Jerry Taciuk, chief executive officer	
Andrew Musial, president	

*Continued overleaf*





S-25

S-25

ISSN 1180-3274

**Legislative Assembly  
of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

Tuesday 30 November 1993

**Journal  
des débats  
(Hansard)**

Mardi 30 novembre 1993

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Regulated Health Professions  
Amendment Act, 1993

Loi de 1993 modifiant la Loi  
sur les professions de la santé



Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 30 November 1993

The committee met at 1533 in room 151.

REGULATED HEALTH PROFESSIONS  
AMENDMENT ACT, 1993

LOI DE 1993  
MODIFIANT LA LOI SUR LES PROFESSIONS  
DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 100, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 100, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

**The Vice-Chair (Mr Ron Eddy):** Members, ladies and gentlemen, welcome to the standing committee on social development, presently holding hearings on Bill 100, An Act to amend the Regulated Health Professions Act, 1991.

TORONTO PSYCHOANALYTIC SOCIETY

**The Vice-Chair:** The first delegation is the Toronto Psychoanalytic Society. Would the representatives please come forward and sit at the mikes, introduce yourselves, and proceed with your presentation. We have approximately 15 minutes for a presentation, followed by questions if there's time. Thank you. Go ahead.

**Dr Paul Finnegan:** Mr Chairman and members of the standing committee on social development, my name is Paul Finnegan and I'm the president of the Toronto Psychoanalytic Society. This is the second time within a month that I've had the privilege to appear before you and to express the concerns of the Toronto Psychoanalytic Society and other Ontario branches of the Canadian Psychoanalytic Society. Appearing with me today are Dr Ray Freebury, the director of the Toronto Institute of Psychoanalysis, and Dr Patricia White, a member of both the society and the institute.

As you may recall from our previous presentation, there are over 150 psychoanalysts currently practising in Ontario and 30 candidates in training. Of this number, approximately 90% are physicians qualified in psychiatry, while others are psychoanalysts with PhDs in psychology and other related fields.

When practised under highly specialized conditions, psychoanalysis has proven effective in the treatment of mental disorders with resultant reduction in psychiatric hospitalization and in the utilization of other medical services. As this committee has heard from patients themselves, psychoanalytic treatments have alleviated personal psychological suffering and have enabled patients to return to productive lives as parents, employees and taxpayers in this province.

I'll ask Dr Freebury to continue with our presentation.

**Dr Ray Freebury:** I don't know if you are sure of what the Toronto institute means compared to the Toronto society. For your information, the Toronto institute is really the training arm of the Toronto society, and I really represent the society here today and not the institute.

The conditions previously mentioned under which psychoanalysis is properly practised provide the cornerstones of effective treatment. Psychoanalysis is practised under conditions of absolute privacy and confidentiality. Any breach of this confidentiality by a psychoanalyst is not only a breach in therapeutic technique but also a breach of the ethical principles which govern the practice of psychoanalysis.

Under these conditions of absolute confidentiality, psychoanalytic treatment requires that the patient, what we call "free associate," which means they're expected to say anything that comes to their mind, which includes all of their memories, thoughts, feelings, ideas, fantasies which may come to mind during the treatment session. The patient must be free to reveal the most private and intimate details of his or her personal life without exception.

The psychoanalyst fosters the development of trust by providing a receptive and non-judgemental therapeutic relationship and by not acting to intervene in the personal life of his or her patient. The development of trust in the psychoanalytic relationship is a complex and fragile process at times. It sometimes takes a long period of psychoanalytic treatment to establish the conditions of trust which will enable the patient to reveal himself to the psychoanalyst in ways which permit the resolution of their psychological difficulties.

As psychoanalysts, we do have fairly extensive experience of the treatment of patients who have been sexually abused. A recent survey, which will soon be published in the American Journal of Psychiatry and undertaken by a member of the Toronto Psychoanalytic Society, surveyed all of the psychoanalysts in Ontario and his figures reveal that over a third of all of the patients who are currently in treatment with psychoanalysts in Ontario have either been sexually abused or physically assaulted at some time during their childhood, adolescence or adult life.

As professionals dedicated to the care of the mentally ill and to the care of the sexually abused, we strongly support all the initiatives designed to eradicate the sexual abuse of vulnerable patients. We strongly support Bill 100 and the principle of mandatory reporting for the two categories of sexual abuse involving sexual contact. We do concur with the view of the Ad Hoc Coalition of Regulated Healthcare Associations that problems exist with the proposed mechanism for the mandatory reporting of remarks and behaviours of a sexual nature and that more work needs to be done in this area.

In addition, we are deeply concerned about the effects of certain provisions of Bill 100 on some of our patients and on the treatments which we provide. In particular, we're concerned with the unconditional nature of mandatory reporting which runs counter to the very cornerstones of effective psychoanalytic treatment, namely:

First, the assurance of absolute confidentiality; second-



ly, the development of trust; thirdly, the fundamental principle for psychoanalysis of free association; fourthly, the provision of a non-judgemental therapeutic relationship without intervention in the personal life of the patient.

Clearly, there are some circumstances in which the rule of unconditional mandatory reporting will harm patients and seriously undermine their psychoanalytic treatments. The people about whom we speak are not able to come here before you as some of the more courageous victims of abuse have been able to, nor can we divulge their confidences to you. So what I'm about to tell you are hypothetical case examples which are extrapolated from actual clinical situations and experience.

#### 1540

A female patient reveals, during the course of psychoanalysis, that she previously had an affair with her dentist. At the outset of the affair, the professional relationship was terminated. Subsequently, the affair was broken off by mutual agreement and both individuals are now happily married and remain friends.

The psychoanalyst informs the patient that the circumstances of the affair must be reported to the college of dentistry. Over the ensuing weeks, the patient passes through phases of shock, disbelief, rage, bargaining and finally guilty and despairing depression. She fears that by revealing the story of the affair, she will have brought unintended harm upon her former dentist. She refuses permission for a report to be made. Despite her continuing need for psychoanalysis, she threatens to break off treatment if her psychoanalyst reports against her will.

Another example concerns the case of a woman who has had a 10-year history of psychiatric treatment and hospitalization for anxiety, depression and attempted suicide. As a consequence of the trust built up during psychoanalysis, she's able to reveal to a therapist that she had once become sexually involved with her family physician. She feels confusion and guilt about this relationship and is desperately afraid that her husband will find out about what happened and will leave her. It is further discovered that the patient had been sexually abused by her father during childhood and adolescence and that the patient had buried all memory of these events from her conscious mind.

The patient comes to understand that her psychoanalyst is required by law to report the family doctor with whom she had become sexually involved. The patient reasons that when this is done, her husband and family will find out what has happened, and further, the fact that she had been sexually abused by her father will be similarly revealed.

The reporting of sexual abuse has become equated in the patient's mind with the public revelation of childhood abuse which she has long sought to conceal from others and even for many years from herself. She no more trusts in the provisions for anonymous reporting than she could trust the intentions of a psychoanalyst who would report against her will.

The emotional stress of the threat of revelation becomes more than she can bear. An emotional break-

down ensues and she suffers once again from the symptoms of anxiety, depression and thoughts of suicide for which she had initially sought psychoanalytic treatment. The patient has to be hospitalized and the benefits of her previous treatment are lost. Her analyst is now perceived to have joined the ranks of her abusers before she has had the opportunity to understand how the denial of past abuses is continuing to contribute to her persistent and disabling psychiatric, emotional symptoms.

The effect of unconditional mandatory reporting in such circumstances is to further traumatize the patient and to create a cycle of cumulative trauma from which the patient perceives there is no escape. The psychoanalyst is forced to abandon the basic cornerstones of psychoanalytic treatment and to enact a role with which the abused patient is already too familiar, that of yet another authority figure who will betray her trust.

You can see that in all likelihood such an event is going to terminate her psychoanalytic relationship, and the physician who feels obliged to report against the patient's will, because of the threat to his livelihood and so on, is probably going to have to terminate the treatment and try to make arrangements for the patient to begin all over again with someone else.

The ethical conflict into which the psychoanalyst is forced, then, is that of determining what in his or her clinical judgement is clearly in the patient's best interests, that is, not reporting in order to maintain the integrity of the conditions known to be necessary for effective treatment or weighing this against the legislated obligation to report and the dangers this will impose then upon the treatment process.

Many patients requiring psychoanalytic treatment have had their basic trust repeatedly betrayed in the past, with terribly damaging consequences. To legislate that their trust be betrayed yet again by those to whom they have come for help is to do grave harm to such patients, to seriously damage their treatment and to compromise their hopes for recovery.

At this point, I'll hand back to Dr Finnegan, who would like to make a more formal proposal.

**Dr Finnegan:** I just want to remind the committee that we support Bill 100 and we support mandatory reporting, but we feel here that Bill 100 must be strengthened in its intent to protect the public by being modified to reflect the needs of a small group of particularly vulnerable psychoanalytic patients. The modification required is that psychoanalysts must be allowed, under clearly specified conditions, an exception to mandatory reporting as it's defined in the bill.

With the assistance of legal counsel, we'll now put before you a proposal for the strengthening of the provisions of Bill 100 which we believe will be to the benefit of patients under the special circumstances of psychoanalysis.

We propose the following exception to mandatory reporting which would be either an amendment to subsection 85.1(4) or, alternatively, included in the regulations under subsection 85.1(4):

"Whereas psychoanalysts—to be defined as members

in good standing of one of the Ontario branches of the Canadian Psychoanalytic Society—provide treatments, psychoanalysis and psychotherapy which, by their very nature, require that a patient be absolutely truthful about and fully disclose what are ordinarily considered to be the most intimate and private details of his or her personal life; and

“Whereas psychoanalysis and psychotherapy are treatments which, by their nature, require standards of absolute therapeutic confidentiality in order to be effective;

“Psychoanalysts, while engaged in the provision of psychoanalysis and psychotherapy, are permitted an exception to the mandatory reporting of sexual abuse of a patient by a member of the same or a different college in circumstances in which:

“(1) The psychoanalyst finds out about the abuse during the course of treatment of the patient;

“(2) The patient refuses permission to report; and

“(3) The psychoanalyst determines that in his or her clinical judgement reporting will risk serious harm to the patient or will substantially interfere with the patient’s psychotherapeutic treatment.”

I want to just go back and note that at the end of point (2), there’s an “and” that should appear in your copy, and I take responsibility for the oversight of that being left out. The implication of that is that conditions (1), (2) and (3) would all have to apply.

Again, we support mandatory reporting, but there is a need for exceptions in the circumstances that we’ve indicated. A concern might arise that exceptions will be used in some way to shield or protect abusers. This must not happen.

To ensure that it does not happen, we believe that psychoanalysts must be professionally accountable in circumstances in which an exemption is claimed. This could be achieved by an amendment to subsection 51(1) of schedule 2 of the code to add the following clause, and by “code” here I’m referring to the health professions procedural code, which is part of a schedule of RHPA, schedule 2, which sets out the procedures in committees, complaints, discipline and so on, common to all regulated health professions. This would be the proposed amendment to subsection 51(1), and would read:

“(b.2) The member has failed to maintain the standard of practice of the profession in exercising his or her decision to claim an exception to the filing of a report of sexual abuse pursuant to subsection 85.1(1).”

In other words, we’re proposing here that if one were to use the exception to shield someone or to use it inappropriately, this would be considered an act of professional misconduct and be disciplinable.

We’re now prepared to answer questions if you have them.

**The Vice-Chair:** Ms Haslam, did you have a question? I thought you’d indicated.

**Mrs Karen Haslam (Perth):** Yes, I did have one if you’re going to give me the time to ask.

**The Vice-Chair:** It is very short, the time.

**Mrs Haslam:** I was interested that you had so many cases. I had a case also and maybe you’d like to comment on this particular case.

There are five instances of fondling re Dr X. The sixth case is reported with the patient’s name. Evidence is of a similar fact. Six women over three years have said they were fondled after a routine exam by Dr X, and that preceding this he made degrading comments about their body. The eventual complainant is validated and investigation of the case is expedited, thereby saving the college time and money and sparing the complainant needless revictimization. Giving you a case, could you comment on that one?

**1550**

**Dr Patricia White:** It seems to me that’s a very important case that would be covered by mandatory reporting if such a case came to the awareness of a psychoanalyst or psychotherapist. It’s obviously a case of repeated abusive behaviour on the part of a particular doctor and needs to be stopped. That’s what mandatory reporting is about, to stop situations where there is repeated abusive behaviour on the part of a therapist or doctor.

**Mrs Haslam:** That’s my point. Without the mandatory reporting, whether there’s a name attached or not, the pattern does not emerge.

**Dr Patricia White:** As we’ve tried to indicate, we are in favour of mandatory reporting except in certain exceptions.

**Mr Cameron Jackson (Burlington South):** Ms Haslam has asked you a specific question about a hypothetical case but involving a physical examination. It’s highly unlikely that in the course of your work you’re doing physical examinations.

**Mrs Haslam:** No, and that was never the intention.

**Mr Jackson:** I understand that. I just wanted that for clarification.

**Dr Finnegan:** Oh, certainly not, yes.

**Mr Jackson:** That’s what I understand. So I’ll ask you a question if I can in terms of the psychological implications of the concept of reporting.

It’s my understanding that currently the practice in Ontario is that although we prescribe zero tolerance and we recommend reporting, if a woman who has been raped or sexually assaulted or physically abused enters a shelter or a rape crisis centre, it’s not automatically required that they report to the police, and there are some time-honoured reasons for that. I don’t want to get into all of that, the discrimination in our justice system, the revictimization and processes and so on, but there’s an acknowledgement there of a woman’s right at that point to make certain determinations that are empowering. I want to try to bring that into the scope of your practice, because we may be producing a form of contradiction here if in fact we compel a patient along a disciplinary route which can actually reverse and harm the patient. This flies in the face of your responsibilities as healers, seeking psychological strength and support.

I want you to expand on your recommendation, because just at the very close of your presentation, you



shared that with us, and I was trying to hear very clearly. I don't have the actual wording of your recommendation in front of me, not that I need it at this moment, but perhaps you could just clarify how we might treat this case differently as it relates to your work, because I think it's rather unique with respect to the whole scope of medical services. I think the bill should clearly make sure it has some recognition of that.

I didn't want to demean your physical examination example, but I really want to zero in on the concept of the psychological consequences of setting in motion matters that are generated by the patient through the therapy process if then they lose control over them, which is not very helpful.

**Dr Freebury:** What I'd like to stress is that, as we've stressed in our presentation, there are certain people who will undoubtedly be harmed by the consequences of mandatory reporting. I think as psychoanalysts, if we had a concern that there was a case of multiple abuse that would be hindered by the patient's refusing to report, we would likely arrange for our patient to be transferred to another therapist and we would report. It wouldn't be the most satisfactory condition for the patient, but we do have to recognize that the public interest has to be protected also.

**Dr Finnegan:** May I speak briefly to that? I'd just like to indicate that in what we're proposing, we're proposing that all three conditions be met. So if the patient simply says, "I refuse you permission to report," that doesn't stop the reporting. We would go ahead and report if we felt that was the proper thing to do to protect the public. The implication for psychoanalytic treatment of reporting against the will of the patient would be that, as Dr Freebury put it, we would be required then to transfer that patient's care to some other psychoanalyst. It would compromise our treatment entirely.

**Mr Jackson:** The trust would be broken.

**Dr Finnegan:** That's right.

**The Vice-Chair:** Mr Wessenger has a question for you.

**Mr Paul Wessenger (Simcoe Centre):** Are you aware that under the bill, for instance, if the name of the abuser is not known, no report can go forward? If the abuser is not known, there's no requirement that a report be filed. You're aware of that?

**Dr Finnegan:** Yes, I'm aware of that. But if I can just follow up on that, I read in Robert Sheppard's column in the *Globe and Mail* a little while back that the idea was being floated around the ministry that physicians could avoid this problem just by telling their patients, "Don't tell me who it was." How could we do that? We're psychoanalysts. We say to our patients, "Tell us everything." We couldn't possibly buy the situation where they say, "Well, here's something I won't tell you."

**Dr Freebury:** It would hardly be conducive to psychoanalysis to be duplicitous and to promote duplicity with one's patient.

**The Vice-Chair:** Thank you very much for your presentation.

#### ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

**The Vice-Chair:** The next presentation is by the representatives of the Royal College of Dental Surgeons of Ontario. Would the representatives please come forward and be seated and introduce yourselves. Proceed with your presentation after introduction, if you would.

**Dr Richard Beyers:** Good afternoon, ladies and gentlemen. My name is Dr Richard Beyers and I am president of the Royal College of Dental Surgeons of Ontario. The college is a regulatory body of the dental profession in this province. We are charged with the responsibility of governing dentistry in the public interest.

With my today are Dr Minna Stein, our deputy registrar, and Mrs Solette Gelberg, one of the five public representatives appointed to our council. Mrs Gelberg will present on behalf of the college an overview of the written submission which we have provided to you. We hope that our input will assist you in developing effective legislation to eliminate the sexual abuse of patients.

**Mrs Solette Gelberg:** You've been provided with the college's written submission and I would like to highlight some of the points that have been raised.

The Royal College of Dental Surgeons not only views the matter of sexual impropriety and sexual abuse with utmost seriousness; it will not tolerate any actions of this kind on the part of the dentists in Ontario. However, while the college welcomes further positive legislative change, it must oppose amendments which will lessen its ability to regulate dentists effectively.

The college is concerned that some of the proposed provisions may unintentionally make it more difficult for colleges to prosecute members successfully. If the charge of sexual abuse covers everything from a remark to sexual intercourse, it may sometimes be very difficult for discipline committees to find professionals guilty as charged. Indeed, it may be that discipline committees will find themselves applying an exceedingly high standard of proof, possibly leading to undeserved acquittals. This surely is not in anyone's interest. As in the courts, discipline committees dealing with sexual impropriety or sexual abuse often find there are no witnesses and no real evidentiary basis to support a finding of guilt. In the end, they must rely on the credibility of witnesses and reports of surrounding events to determine who is telling the truth.

Two changes are required. First, in our view, it would still be preferable and in the public interest for two categories of offences to be established: sexual impropriety for remarks and gestures, and sexual abuse where any physical contact is involved.

Second, there should be a range of fines and penalties for both categories, depending on all of the circumstances involved, with some discretion left to the discipline committee regarding the length of waiting time before application for reinstatement. It's difficult to understand how anybody can contemplate the same charge for an inappropriate remark, hugging and rape.

The college encourages the ministry to follow through on its consideration and allow the college to refer mem-



bers charged with behaviour or remarks of a sexual nature to assessment and possible remediation rather than to discipline.

While the college agrees with mandatory revocation for sexual abuse with physical contact, a five-year removal from practice for a dentist will in most cases effectively end his or her professional career. It is impossible to practise dentistry or to stay current with techniques without performing the controlled acts of the profession.

**1600**

However, there are other professions where the person may continue to work in their field even though registration has been revoked. The proposed amendment is an unequal application of penalty which does not acknowledge this diversity among the professions.

We recommend that the waiting period before a dentist can apply for reinstatement be one year. Reinstatement would be far from automatic, because the member would have to satisfy stringent requirements for reinstatement as set out in the regulations. Eliminating judicial appeals of penalty because a specified revocation is mandatory also causes concern. The fairness engendered in the principles of superior court review of judicial and quasi-judicial decisions should not be discarded.

Regarding procedures at discipline hearings, the college strongly supports the proposed amendments which would require prior disclosure by both parties of the identity of experts who will testify, along with advance copies of the expert's report or, if there is no report, a summary of the expert's evidence.

The college believes that a discipline hearing has only two parties, the college and the accused member. The only other people who should be allowed to participate in a hearing are those with information relating to matters affecting personal rights, such as competency, and victims, who should be allowed to present impact statements at the penalty stage of a hearing.

The college supports awarding costs against a member found guilty of professional misconduct and recommends extending this provision to reinstatement proceedings. Since the average cost for a day of discipline hearings at our college is approximately \$10,000, this will be an added inducement for members and their lawyers to cooperate with the college so that investigations and discipline proceedings can be more expeditious and less costly.

The college is concerned about the provision requiring funding for counselling. If a finding of professional misconduct against the member is a prerequisite for entitlement to counselling, this can be very unfair to the patient. On the other hand, how can you reconcile providing an entitlement to \$10,000 of treatment where a decision of a discipline committee is overturned on appeal? Do you try to get the money back from the patient? Would it not be preferable to make treatment more readily available to all through conventional avenues like publicly funded community mental health services? Colleges are inappropriate bodies to administer counselling funds.

The college supports mandatory reporting of sexual

abuse involving physical contact. It opposes mandatory reporting of remarks and non-physical behaviour, despite the government proposal to qualify remarks and behaviour to that which is demeaning, seductive or exploitive. There is just too much room for subjective interpretations to be incorrect. In any case, the reality is that there is little the college can do with a third-party report of this type of misconduct if the victim is unwilling to press the matter. The better approach would be to require members to ensure that victims are informed of their own rights to complain to the college.

Regarding mandatory reporting by treating professionals, the college entreats the ministry to reconsider providing some exemptions in this area. If a mandatory reporting provision continues to apply to treating professionals under all circumstances, we feel this will deter dentists who need help from accessing the treatment they need and a valuable means to prevent sexual abuse will be lost.

Section 4 of the bill proposes to prevent a registrar from referring a dentist to the registration committee on reasonable grounds to doubt the applicant's capacity. Experience has shown that applicants may meet all the paper criteria for registration but there may still exist good and valid concerns about their capacity or good character and the effect this could have on their dealings with patients. To remove this protection from the public makes no sense to the college. A better amendment would provide that a registrar may refer an applicant to the registration committee when the registrar has doubts, on reasonable grounds, about the sufficiency of the applicant's education, training, experience or capacity or about the applicant's character.

While we've supported some provisions of Bill 100 and some of the proposed revisions, it is clear that we do not agree with others. However, we wish to assure the standing committee that the college is committed to eliminating sexual impropriety and sexual abuse by dentists. It has amended its procedures to this end and will continue to make any changes that are found to be necessary and in the public interest.

We know that effective legislation is a prerequisite to carrying out our mandate. We ask that the standing committee heed our advice and that of many other experienced governing bodies so that the RHPA will have workable provisions which will allow protection for all involved.

We thank you for your time today. We have a copy of my submission, if it would help you in your deliberations, and we are certainly willing to entertain your questions.

**The Vice-Chair:** Thank you. Are there any questions?

**Mr Larry O'Connor (Durham-York):** One question, referring to page 10 of your brief, paragraph 24, the last sentence, on the hearings: "Secondly, it would be permitted to allow victims to present an impact statement at the penalty stage of hearings." I thought I'd let you expand on that. To me, it would seem that as a college goes through this process, it might want to hear from the victim at an earlier stage than at the stage where it's going to be setting the penalty. This being as serious as it is, it seems you might want to hear from the victim

sooner. I'd like to have your comment on that.

**Mrs Gelberg:** I'll let Dr Stein answer that.

**Dr Minna Stein:** Actually, during the course of the discipline hearing, the victim does have a role earlier on. The discipline hearing is made up of two hearings. One is the hearing as to the finding of guilt or innocence, and the second part of the hearing is with regard to penalty. In the first part of the hearing, where the question of guilt or innocence is being determined, the discipline committee does hear from the victim in terms of finding out what the facts are, the facts to permit them to have a finding of guilt. If they do find the member guilty, then the penalty phase of the discipline hearing starts, and at that point the victim should be allowed to present an impact statement so the committee can take into account the impact this abuse has had on the victim when they in turn give the penalty to the dentist.

**The Vice-Chair:** Thank you for your presentation.

1610

#### ONTARIO BOARD OF EXAMINERS IN PSYCHOLOGY

**The Vice-Chair:** The next presentation will be by representatives of the Ontario Board of Examiners in Psychology.

**Dr Catherine Yarrow:** Good afternoon. I'd like to introduce myself and my colleagues. I'm Catherine Yarrow, the acting registrar for the Ontario Board of Examiners in Psychology. Beside me is David Lumsden, a public member of the board of examiners in psychology, and beside him is Ronald Slaght, our general legal counsel. Unfortunately, another public member who also planned to attend today is at home in Ottawa nursing a severe case of bronchitis and sends her regrets that she wasn't able to participate.

In reviewing the provisions of Bill 100 and its predecessor, Taking Action Against Sexual Abuse of Patients, the board noted and endorsed two goals that were stated by the Ministry of Health in introducing this legislation protecting potential victims of sexual abuse and protecting victims who have been abused from being abused a second or third time, being victimized again.

In reviewing the legislation, our board was concerned about whether this legislation has met those goals, whether the legislation can be implemented effectively in the regulatory process and whether it adheres to fairness, which will also speak to how effectively we can implement the legislation in regulating the profession and protecting the public.

Our board has a history of standards which proscribe sexual intimacies with clients. As far back as the late 1970s, our board developed standards and enforced them in the disciplinary process, proscribing sexual intimacies with clients. In the 1980s, sexual misconduct was introduced into regulation in our profession, in regulation 825, and in 1989, our profession held a workshop for members of the profession about the whole issue of sexual abuse of clients so that they might be more aware of the issues and understand the concerns.

Today, I'd like to speak to some of the issues from the point of view of the regulator. I'll ask David Lumsden to speak to some issues from the perspective of a public

member of the board, and then if you have questions, we would welcome questions of any of the three of us.

Our initial concern with Bill 100 was with the actual definition itself. The term "sexual abuse" raised concerns for us inasmuch as there's some difficulty shoe-horning the three (a), (b) and (c) definitions into abuse, and we may at some point run into some argument about what's abusive and what's not. From the point of view of our profession, it's misconduct to engage in any of the three behaviours listed in the definition. We don't really wish to enter into defence arguments about whether it's abusive or not. We've defined it as misconduct, and we would find the term "sexual misconduct" far more useful to us in the overall definition than "sexual abuse."

Furthermore, the definition limits itself to trying to specify which acts will be considered misconduct for the purposes of discipline. We do not wish to limit our tribunals quite so rigidly, and we would like to include the phrase, in the introductory line of the definition, "includes but is not limited to." That allows for occasional circumstances where clearly misconduct has occurred, but on a technicality, a successful defence might manage to avoid prosecution. Frankly, that would be a tragedy and that would be quite counter to the spirit of this legislation and quite counter to our own goals as a regulator protecting the public.

Dr Lumsden will speak a little further to an additional concern we have about the definition.

With respect to the matter of mandatory reporting, we have had certainly a voluntary reporting provision in our guidelines to the profession for a number of years. We even have some guidance about when it might be appropriate to report to the college as opposed to confronting a fellow professional.

We have some concern raised if there were to be a provision of across-the-board mandatory reporting if a client was not ready to be named or to come forward. The first concern is a prosecutory one, that is, that we would most likely not be able to go forward with discipline, in the absence of a witness willing to testify, unless we were able to fortuitously come up with some other evidence that we could use in discipline.

In addition to that, our own experience has revealed to us that not only are some of our members potential offenders committing sexual misconduct, but when they know that something is afoot and a report has gone in to the board or might go in to the board, they may actually intimidate the client. Even though they may not know the name of the client or may not have been told or may not have been advised of a name, they can guess pretty well which case it is that's come to the attention of the board. We have some serious concerns about safety issues for the clients if mandatory reporting were to be required in all circumstances of this nature.

We do nevertheless endorse the view that professionals should take responsibility for each other. There's one particular exemption, however, that we would like to seek that's of particular relevance to our profession, which is a treating profession that might well be treating individuals who have committed some of these acts and engaged in the conduct described in this legislation. We would



like to seek an exemption for anyone in the course of providing such treatment having to report to the college an admission in this confidential, trusting relationship that the individual has engaged in this type of conduct unless the treating therapist, the treating professional believes there is a continuing risk of harm. In that case, it would be expected that the professional would report. We still hold the view that public protection is critical and if there's continuing risk, there's absolutely no question that we would want that provider to report.

With respect to reporting by employers, we don't have concerns about that. It's just a minor wording change. Some members of our profession would like to argue that they offer services which are broader in scope than those defined by "health" services, so we'd simply rather insert the word "professional" services rather than restrict it to health services.

Finally, our board endorsed the removal in the ministry's amendments of the requirement for reporting across professions of other types of misconduct, incapacity and incompetence, as our board thought it would be very difficult to be able to identify particularly incompetence in members of other professions and difficult to judge one another's activities. But certainly in the sexual abuse domain, we don't have concerns about the requirement for mandatory reporting in that realm.

We do have some concerns that there might be over-reporting with the threat of a fine if these other categories were included in the act and are not sure what protection would be afforded the reporter if a professional, on one hand, were required to report upon threat of being fined otherwise and then if that person did make the report, whether there was any vulnerability to a subsequent lawsuit.

With respect to within-profession reporting, as I say, we have a history of professional standards and guidelines which already deal with that matter and think that's the most important way to proceed within a profession.

Finally, I'd like to speak to the program for funding, and we'd simply like to rephrase the eligibility for the program for funding for therapy. Again, this has to do with our own experience in discipline, that the program as it's described now would be for those individuals who were sexually abused by a member while they were a patient. In our experience, members of the profession who may get involved in sexual intimacies with clients often have a very quick and rapid termination of professional services in order to facilitate the onset of this more intimate relationship. It's not just that these things occur in the therapy hour; sometimes they occur very suddenly after what seems a rather abrupt and inappropriate conclusion of the service provision.

We would rather the wording recognize eligibility for the funding if the individual has been the complainant in any discipline hearing which makes a finding of sexual misconduct or professional misconduct relating to sexual conduct because, as I say, we have this post-termination issue where, really and truly, we would argue there's continuing influence and the professional relationship has not truly ended.

I'm going to let David Lumsden now speak to some of the other provisions in Bill 100.

**Mr David Lumsden:** Thank you for the chance to appear before you. I am, as Dr Yarrow said, one of the three public members on the 10-member board and I'm a full participant in OBEP and in the transition council. I've also been a member of the registration committee. I'm presently a member of the complaints committee and I'm also co-chair of the client relations committee.

As a public member, the first thing I wanted to say was that I fully support all of the recommendations in the OBEP brief towards improving Bill 100. My own concern is, of course, serving and protecting the public, and I want to address briefly four connected issues.

It is vital to secure, first, effective regulation of the profession; second, effective prosecution of offenders; third, effective protection of the public, and fourth, an accessible and fair discipline process for all involved with an appropriate penalty. All these, in my opinion, require changes in the present Bill 100, and in speaking now, I'm going to be supporting recommendations 2, 3, 4, 5, 9 and 10 in the OBEP brief.

First, about effective regulation: As Dr Yarrow has already said, we believe it is a good thing, and I do as well, that Bill 100 will focus on sexual abuse, that issues of misconduct and incompetence across the professions will not be there because it is, I believe, not reasonable to expect that members of one profession will know the standards and practices of all 23 other particular professions. Keep the focus on abuse.

1620

However, it is not conducive to effective regulation, in my opinion, to require mandatory reporting within or across professions regarding sexual abuse or misconduct if there is no patient or client name attached to the document. Yes, all of our members are to be encouraged to make sure that potential claimants do come forward or allow their name to come forward. Yes, it is the responsibility—and the college is going to live up to that—to make sure that there's adequate publicity and access for the general public to get into our complaints process. We have in fact recently added yet another investigator to the board to help ensure that. But without a name of a complainant, nothing can really be done with a report. It's a useless piece of paper in many ways, and it raises real confidentiality and danger issues. One simply can't prosecute on the basis of that document without a complainant's name. So I would support recommendation 5, deleting that aspect.

Under effective prosecution, I very strongly support our recommendation number 3, which is asking that the intervenor status for both the complainant and for any related advocacy group be deleted from Bill 100. That is to say, what I'm arguing for is that we leave the present process of the college disciplinary tribunal prosecuting the case intact. Let them make their decisions and not add anything further to the process.

I am personally very, very much impressed by the danger that a truly guilty practitioner will get off, because there would be, under this present idea of an intervenor



status, more people involved, more lawyers involved, more witnesses brought forward, and the more people brought in like that, there's a real danger, in my opinion, that grounds for appeal will arise in the course of that lengthy hearing. I am convinced that our college does prosecute, and the bill threatens to undo that good record, in my opinion.

However, I would also say that the complainant very definitely does have the right to be present throughout, does have the right to have a support person of their choice present throughout, but otherwise not actively participating, does have the right indeed to provide an impact statement to the disciplinary tribunal and a finding of guilt before the penalty is decided. That is fair. Therefore, I'm asking that the intervenor status section be deleted.

Further, I would say that deletion also saves time in a hearing, even more so now that the Ministry of Health is suggesting that indeed the idea of disclosure 10 days in advance be extended to any such intervenors. That will indeed, in my opinion, give rise to at least two sets of hearings, one to hear the disclosures and then make a decision and so on and so forth. That will lengthen and indeed enhance the cost and difficulties of the hearing.

Further, it's not effective prosecution if the disciplinary tribunal is in any way constrained regarding automatic penalty, regardless of the actual degree of harm to the complainant. Please allow the disciplinary tribunal to look at a full range of penalties. Bill 100, in my opinion, needlessly sets out an automatic penalty without regard to the real harm done. It doesn't even allow for an assessment of the particular complainant. Delete this, as per our recommendation 4.

Let the discipline tribunal truly and freely ascertain the degree of harm, including the degree of harm for remarks and behaviour, because we very strongly do see that item (c), contrary to some groups' opinion, is an area of real harm for some groups, particularly in a multicultural population. For some groups, that joke may well be more shaming than other activities or a joke to another group. So this allows the disciplinary tribunal to go for the real harm and allows for the views of the survivor as to the real impact on her or him to enter into the penalty deliberations.

Let there be then recommendation 10, that is to say, required insurance carried by the college members to truly fund the needed amount of counselling money.

Thirdly, in terms of effective protection of the public, it is not protecting the public, in my opinion, and it's not protecting the survivor if the money for the counselling goes to an unregulated practitioner, nor does this rewarding of an unregulated person with jobs encourage them to seek regulation in a college membership.

Yes, it is true that many survivors believe that once bitten, twice shy. Having been hurt by somebody who is a regulated member, they don't want to go back to anybody who's regulated. However, our concern, and mine certainly as a public member, is that if they do go to an unregulated practitioner, even if they do follow the Ministry of Health's suggestion that there be a form signed so that the complainant recognizes that she or he

is going to see an unregulated practitioner, there is no protection for that person from being revictimized. They have no college to appeal to for discipline if they're going to an unregulated person.

What I would recommend instead is that each college provide the complainant, the survivor, with a list of regulated practitioners from which they themselves can choose whom they wish: female or male, style of approach, school of theory, whatever. There is some choice, they do have some control over it, and certainly then the college is able to live up to its mandate to protect the public by making sure these victims of abuse do not go to an unregulated area where they are further, in our opinion, at risk.

Further, with regard to recommendation 10, Bill 100 very inappropriately, in my opinion, requires that the money for the counselling be overseen and disbursed by the very same body which is also charged with prosecuting the case. In other words, there will be an inevitable perception of conflict of interest. The same group that is prosecuting is the group that's giving out the money. Therefore it's obvious that some people will say they won't be interested in really seriously prosecuting because it's going to cost them money.

We would urge, therefore, keep the colleges at arm's length from the counselling fund. Let an insurance carrier handle it and handle the disbursements, and that way the mandates of the colleges to protect and serve the public will indeed be adhered to.

Finally, let me just emphasize that indeed this college, all of us on it, are committed to making sure there is zero tolerance of the behaviours indicated. On that note, I would like to end.

**The Vice-Chair:** Thank you very much for the presentation. Unfortunately there's no time for questions, but we do deeply appreciate your presentation.

SYLVIA BRADLEY

**The Vice-Chair:** The next presentation is by Sylvia Bradley. Is Ms Bradley present? Good afternoon. Would you introduce yourself and then proceed with your presentation. We have copies.

**Ms Sylvia Bradley:** I have to talk into one of these? My name is Sylvia Catherine Bradley. I'm going to take my hat off.

Preamble: Before I begin my main presentation to you, I would like to apologize for the flood of paper I am now adding to. As an advocate for assaulted women and children, I have made a practice of keeping only minimal notes, for the protection of the women and children for whom I speak, and the prevalent misuse of the disclosure legislation being what it is.

When I prepared my presentation for you on Sunday, I focused on the fact that I would have 15 minutes to present to you my position on Bill 100. I did not realize until I attended the hearings yesterday that I might have asked for additional time, 15 minutes for myself as a survivor and another 15 minutes to speak as an advocate for other survivors for whom I am working.

However, at the hearings yesterday I also noted that the committee is much less formal and time-ruled than I

had feared. Therefore I am asking your indulgence before I begin. My main presentation is timed to slightly less than 15 minutes, but I would greatly appreciate your allowing me to continue for an additional short period of time in order that I may answer some of the questions and concerns raised by members of the committee and some of the professional organizations that presented to you yesterday.

I carry a lot of information—ideas and knowledge and facts—in my head, in addition to the personal information given to me by women for whom I advocate. I'm used to knowing what I know and I forget until I start to put it on paper how much is there. I'm perfectly willing to share these ideas and this information—I don't feel that I own it—but it doesn't occur to me to communicate this information until I'm in a situation, such as the hearing yesterday, wherein it becomes apparent that there are information gaps that need to be filled. So if the committee will indulge my request for a little more time following my main presentation, I will address the issues raised at yesterday's hearings and answer any questions the committee may have for me arising from my presentation. So I will officially begin.

**1630**

As I said, my name is Sylvia Catherine Bradley. On September 30, 1971, I was taken to the emergency department of the Ottawa Civic Hospital. I was extremely depressed, suicidal, homicidal, hysterical and still slightly drunk following a six-week attempt to eradicate the pain precipitated by the breakup of a romantic relationship. I was seen and treated by Richard Hill, MD, an intern from the department of psychiatry. After gaining my confidence and trust, Dr Hill discharged me from the hospital, drove me to my home in his car, gave me more drugs, put me to bed and then raped me. For the sake of brevity, I am giving you, the committee, the Reader's Digest version of the events of that night and my subsequent attempts to bring this matter to justice.

For the purpose of clarification, I have attached to this brief the following materials: (1) My original statement of complaint to the College of Physicians and Surgeons of Ontario, dated September 14, 1991; (2) my response to Richard Hill's response to my letter of complaint, dated December 5, 1991; (3) a press release issued and distributed by me outside the College of Physicians and Surgeons in early September 1992; and (4) a copy of the decision and reasons for decision sent to me by the CPSO on November 11, 1993.

Richard Hill's "treatment" of me is etched permanently and vividly in my memory bank. I was disassociated at the time and I experienced the whole sequence of events from a slightly out-of-body objective position. From that position, it was very clear to me that he knew exactly what he was doing. There was no hesitation, no nervousness, no sudden, spur-of-the-moment action. He was very cool, dispassionate and purposeful, obviously experienced. He knew exactly what he was doing, what he wanted and how to get it. I knew when I reviewed the events that he had done this before. I also knew that he would do this again and that I had to stop him. I felt a responsibility to other women.

At that time, October and November 1971, I felt okay, I was coping. I was being seen by Dr Casselman, a psychiatrist at the Royal Ottawa Hospital, as an outpatient and I had recovered to some degree from my reaction to the breakup of my relationship and my initial shock response to Richard Hill's assault on me.

Knowing of nowhere else to go with this information and believing that she would help and/or advise me, I disclosed the incident and my concerns to Dr Casselman. Her initial statement to me was, "Leave this with me, Sylvia," so I did. Two or three weeks later, at the end of a therapy session, I asked her what was happening about Dr Hill. Her reaction this time was a long pause followed by, "Sylvia, I think it would be best if you just forgot this whole thing."

Unfortunately for me, I was no longer disassociated and her words and attitude hit me like a freight train. I was devastated. The feeling of betrayal was overwhelming, soul-destroying. I turned and left her office in shock. I did not keep my appointment with her the following week, nor did I keep the one given to me by hospital staff when they called to inquire of my absence and rebook an appointment. I did not report Dr Casselman's behaviour or advice to anyone at that time. Who could I tell? What could I tell them? Who would believe me anyway? Dr Casselman had believed me about Dr Hill; I know that from her tone of voice and attitude and demeanour, and she wasn't willing or able to do anything, so where was I to go? Back to the bottle and pills, of course.

She advised me to forget the whole thing, and alcohol and drugs were the only means at my immediate disposal for following her advice. I did that with a vengeance. My use and abuse of alcohol and drugs skyrocketed at that time and I proceeded on a course of active drug and alcohol addiction for the following 17 years. My mistrust of and disillusionment with the medical community was huge, and virtually the only reason I continued to seek any medical assistance was to obtain drugs. The more I used, the more I needed, and I was never able to "forget the whole thing," as Dr Casselman had advised.

In July 1993, at the discipline hearing on my complaint, Dr Casselman was called to testify. Clearly, she had no memory of me or my report to her of Richard Hill's behaviour. Not surprisingly, there was nothing of my disclosure to her in the hospital case notes made by her at that time. In watching and listening to her testify, I wondered how she had done it, how she had managed to follow her own advice to me. It was clear that she had forgotten the whole thing. I wish she could have shown me how to do it.

As a result of the media attention given to my particular complaint, 10 other women have come forward to the college with similar complaints against Richard Hill. In addition, 17 criminal sexual assault charges have been laid against him so far and more women continue to come forward.

I do not doubt that Dr Casselman, now retired, was an adequate and sometimes helpful therapist for others of her patients. I also believe that, had mandatory reporting been the law and not just a vague, ethical/moral obligation at



that time, she would have had to report Richard Hill and he would have been brought to discipline. In 1971, when he raped me, Richard Hill was still an intern. Had he been reported then, it is possible that he would never have been licensed by the CPSO to practise medicine in Ontario and none of these other women would have been assaulted by him while he was ostensibly practising medicine.

Further, although I'm not aware of any complaints that predate 1971, I have no doubt that I was not Richard Hill's first victim. He was very smooth, practised, confident. Perhaps he did not get as far with some of his earlier victims. Perhaps their early warning systems were more functional than mine. Perhaps he needed practice to nail down the exact words and gestures that would get him what he wanted and which words and gestures would set off alarms and ruin his game.

Therefore, I strongly recommend to the standing committee that the sections of Bill 100 dealing with mandatory reporting not be weakened or altered in any way. The mandatory reporting of words and gestures is as essential as the mandatory reporting of actions.

For the rest of my time with you, I wish to address the issue of most recent great concern to me in my dealings with the College of Physicians and Surgeons of Ontario: standing—full party status for complainants.

Bill 100, as it is currently written, would have the discipline processes at the colleges of the regulated health professions function in much the same way as they are functioning under current law. The complainant in this process is only a witness for the college and does not have standing at the hearing. Only the defendant and the college have standing. They are parties to the proceedings. Only parties to the proceedings may call witnesses, cross-examine witnesses, introduce expert witnesses or appeal decisions of the tribunal.

A complainant may be given leave by the tribunal to intervene on certain matters if they want to hear what she wants to say or if she has the money to hire a lawyer to act for her. Otherwise, her participation in the process is limited to testifying as a witness and enduring usually long and intrusive and often abusive cross-examination. She will be encouraged to communicate with the college only through the investigator assigned to her complaint.

In my case, when I attempted to speak by telephone with Joyce Harris, the lawyer for the college, and to encourage her, plead with her to make submissions to the panel on the issue of Richard Hill's competence, she told me (a) that she was not willing to argue for a finding of incompetence, and (b) that I had to remember that she was not my attorney, that she was acting for the college. This conversation took place one week before the complaint was to be heard in July 1993. I fortunately was able to receive some assistance from Marina Browning, a staff lawyer with the Barbra Schlifer clinic. Ms Browning was denied by the panel the right to intervene on this issue, but she did manage in subsequent discussion with Ms Harris to convince Ms Harris to at least put to the panel my desire that Richard Hill be found incompetent.

The first opportunity I was given to meet with Ms Harris and review the college's position did not take

place until the last working day before the hearing was to start. At that time, Ms Harris told me that Hubert Mantha, the lawyer I had retained in 1972 to assist me in having Richard Hill's licence removed, was not being called as a witness by the college. I was aware, from conversations with the college investigator and a subsequent conversation with Mr Mantha, that he was entirely willing to appear as a witness at the hearing. Although he no longer had my file or any written records, he said he remembered me and he remembered the doctor's name, Hill, very clearly, and he remembered that I had come to him primarily out of my concern for other patients who might be assaulted by Richard Hill.

His advice to me at that time was that it would be necessary for me to have some harder evidence in order to have this doctor's licence removed, and therefore he advised me to initiate a paternity suit, assuming that if I won the paternity suit I would then have the evidence necessary to have the doctor's licence removed. I do not recall him advising me at that time that I could go directly to the CPSO. I don't think he did, perhaps because he was aware how unlikely it would have been in 1972 that my complaint would have been taken seriously.

1640

At any rate, Hubert Mantha was not called by the college as a witness. Ms Harris told me that his testimony was unnecessary. She stated that in her opinion my testimony and the testimony of the expert witness that she would call would be sufficient for a conviction. Because I did not have party status, standing, I was not allowed to call him as a witness, and as you will note in the 19 pages of the reasons for the decision—acquittal—given by the panel, his testimony on the reason for my contacting him, my concern for other patients, would have been very helpful. The panel could not understand why I, an ordinary woman, would contact a lawyer, except for financial gain, of course.

Further, the expert witness called by the college testified only to the usual behaviour of victims of sexual assault. No expert witness was called to testify to the usual behaviour of perpetrators of sexual assault. It is very clear from the reasons for the decision that the panel was absolutely unaware of and had received no education on the common behaviour and attitudes of perpetrators.

In the final paragraph before they acquit him, they state that "it would have been unusually bold for a physician to perpetrate the alleged act when the patient had an appointment within hours with Dr Hill's chief." Nowhere do they indicate that they had any awareness of the fact that one of the major features of sexual assault that will enhance its appeal to perpetrators is the element of danger. The more dangerous it is, the higher the risk, the more exciting it is for perpetrators. Rather than viewing my appointment the following morning with Richard Hill's chief as a possible deterrent, the panel ought to have recognized it as a further enticement to him to perpetrate.

When I asked Ms Harris at a later date, after the decision had been rendered, why the college did not call an expert witness to testify on the common and usual



behaviour of perpetrators, she stated that this was a good idea and that this idea had never been considered by the college. I certainly hope that the college will consider it now and implement it at all future discipline hearings.

The CPSO discipline panel hearing my complaint against Richard Hill found "the charges of sexual impropriety not proven" and "the incompetence charge was not proved" on November 9, 1993, despite the fact that 10 other women had come forward to the college, four of them while my complaint was still being heard. Ms Harris felt that there was not enough "similar fact" to adjourn my hearing and call them as witnesses on my complaint. I did not have party status and so I could not insist on seeing the new complainants' statements and judging for myself. Ms Harris also stated that at that time, day 2½ of the hearing, she felt confident that my case was strong enough to warrant a conviction as it had been presented and so she would proceed on my testimony alone. Obviously, the panel did not agree with her.

On November 15, 1993, less than one week later, I was in attendance at the CPSO while a lawyer representing Richard Hill argued successfully to another discipline panel that "witnesses are not the property of either the prosecution or the defence." What he was saying, and what the panel accepted, was that witnesses are kind of joint property. On these grounds, this discipline panel granted his motion for disclosure of the current addresses of the 10 women who had come forward to complain if the lawyer was willing to promise not to give the addresses to Richard Hill.

Hill's defence lawyer would not give the panel such a promise at that time, but the panel left the option open to him. At any time that this lawyer is willing to give them a promise in writing that he will not give Richard Hill the current addresses of the complainants, he will be given their addresses by the college. Recently, a young woman in British Columbia who complained to the College of Physicians and Surgeons in BC about a doctor who had sexually abused her was murdered. The doctor about whom she had complained has been charged with first-degree murder.

As complainants, we are taking enormous risks, not just with our reputations but with our lives. As witnesses with no standing, we must depend on the college for protection and justice, and clearly it is either unwilling or unable to give it to us. The only way complainants can be assured of some degree of justice and the only way we will be able to maintain some control over our physical safety in the discipline process is if we are given, in law, full party standing.

If the 10 complainants about to embark on the discipline process at the CPSO had full status, they would not be just witnesses, property to be haggled over. Women have been persons in this country, not just property, since 1929.

In closing, I need to state that full party status will be virtually meaningless to most complainants unless they are also provided with the resources with which to exercise this right. In my opinion, these costs should simply be viewed as part of the costs of self-regulation and be absorbed by the profession affected. There is no

reason why the discipline panel should not be able to order a repayment of the costs to the college for the complainant's legal expenses against the defendant on a finding of guilt.

As a further note, on my particular complaint, because I was not a party to the proceedings, as were Richard Hill and the College of Physicians and Surgeons, I have no right to appeal the panel's decision to the courts. The college could appeal the decision on my behalf, but I judge from the hurried and evasive conversations in which I have been able to engage Ms Harris on this issue that an appeal from the college appears unlikely. Any appeal would have to be filed by December 9, 1993. The college has given me no indication that it will do this, even though I have been told by employees of the college that I am a hero in their eyes. Being a hero to the college is small comfort.

The Criminal Injuries Compensation Board informed me that it will accept an application for compensation from me only with a finding of guilt. If I am strong enough to endure the criminal proceedings, I may be able to apply after the courts find him guilty; maybe not. We'll see.

Please, ladies and gentlemen, amend Bill 100 to give complainants automatic full party standing in disciplinary hearings on all cases of sexual abuse. Please do not let what I have endured go for nothing. Amend Bill 100 so that it more adequately serves the interests of justice and protects the public.

**The Acting Chair (Mrs Yvonne O'Neill):** Thank you, Ms Bradley. It is true that yesterday there was some flexibility in the timing. I would at this moment offer one question to each caucus if they so wish. If not, we will proceed to the next presenter. Is there any question for Ms Bradley?

**Mr Jackson:** Thank you very much for your very cogent and compelling story for this committee. My concern is that the bill discriminates against victims. If you're victimized outside of the medical profession, you have access to certain rights—limited rights, but you have access to them. But the process of Bill 100 limits victims' rights.

You clearly have come forward as a victim and you've clearly indicated that this bill needs serious amendment. Can you answer to this committee how you feel that we would lock in place these circumstances for victims, as set out in Bill 100, while victims' rights are increasing for the general public at a growing rate across Canada for a whole variety of other complaints?

**Ms Sylvia Bradley:** I'm sorry; I'm not clear what it is that you are asking me.

**Mr Jackson:** You will have access to the Criminal Injuries Compensation Board if you can prove in court that you were sexually assaulted. Once this bill takes over, my understanding is that you won't really have that automatic right to go to court and that your access to criminal injuries compensation, as one example, will evaporate, because you will be locked into the process of Bill 100. Bill 100 isn't law yet, so you still have those rights.

**Ms Sylvia Bradley:** Are you suggesting that when Bill 100, as it is currently written, is passed, it will be an either/or choice, either I complain to the college or I can go to the police and lodge a criminal complaint? Is this what you are telling me?

**Mr Jackson:** I would let the parliamentary assistant, himself a lawyer, explain to you whether or not you would be able to file a complaint to the college and undertake legal action simultaneously.

**Mr Wessinger:** I'm going to ask legal counsel to clarify that for the committee.

1650

**Ms Christine Henderson:** Any survivor may simultaneously complain to the college and commence the civil suit if she wishes to do so, and also may of course complain to the police to involve the criminal justice system. Absolutely. In fact, if I may just say, as I said at the briefing last week, the subrogation provisions in the original bill have been replaced with a government motion that provides the college with a narrow statutory cause of action to proceed against a perpetrator to recover any funds that were expended for the therapy or counselling of a survivor. So the subrogation rights that would have accrued to the college no longer do so and there is absolutely nothing that would impede a survivor to sue civilly along with the report going forward or the complaint proceeding to a discipline committee.

**Mr O'Connor:** Thank you, Ms Bradley, for being here. You've been through quite a few of our hearings to this point. I appreciate you being here, taking the time and making this difficult presentation.

You stated in your presentation that there should be no softening of any of the mandatory elements of it. There's been a change on (c), around the behaviour or remarks. You heard yesterday that this just muddies it. You heard the presentation before you saying: "Because we're psychoanalysts, we might hurt somebody by reporting this. We might further victimize the patient." I'd like to have your comments, as a victim, on that, if I could, please.

**Ms Sylvia Bradley:** Certainly. I will read you what I wrote in Further Thoughts after Attending November 29th Hearings. It addresses this issue.

First, I heard the fear expressed by a representative of the Ontario Massage Therapists Association about the possibility of inappropriate cross-discipline reporting. His concern is, in my opinion, not entirely unfounded. In my experience, many professionals are highly educated only in their own fields and might misinterpret activities with which they are unfamiliar. However, this whole issue can be easily addressed if all the colleges of the regulated health professions immediately introduce their members to these different techniques through the education programs on the topic of sexual abuse that they will be required to provide when Bill 43 is proclaimed into law. Perhaps the massage therapists association would be willing to provide speakers to the other RHP colleges to assist in the education of their members.

Next, I attended most of the committee hearings yesterday and I heard again the same concern expressed

by more than one professional body. I specifically recall the OMA section on psychiatry and the Ontario Psychiatric Association presenting similar arguments about how mandatory reporting of words and gestures would certainly adversely affect their therapeutic relationships with certain mythical groups of patients.

First, we are only talking about mandatory reporting, not mandatory official complaint filing or mandatory disciplinary hearing attendance. Patients with any concerns can be simply and gently reassured that their anonymity is guaranteed and that they need never be contacted, let alone proceed with any college process. If the patient is confident in the integrity of the professional, there will be no threat to the therapeutic relationship.

And confidentiality is not an issue, second. We, survivors and survivor advocates, have been saying this over and over and over and over again to concerned professional bodies in numerous consultations over the past six months. Once again, I must express my frustration at not being heard. I no longer believe that these expressed concerns about mandatory reporting have anything at all to do with patients or patient confidentiality. They have to do, in my opinion, with an absolute unwillingness on the part of some professional bodies to assume the responsibility inherent in the tremendous power given to them by the public.

I would suggest that if this committee is truly interested in patients and the needs and desires of patients, it would be far more useful and productive for you to listen to the positions being expressed to you during these hearings by real live patients and survivors and their advocates than to involve yourselves deeply with the possible fears of hypothetical groups of patients presented you by not unbiased professionals.

**The Chair (Mr Charles Beer):** Final question, Mrs Sullivan.

**Mrs Barbara Sullivan (Halton Centre):** I don't need it now; it's been covered in the response to the last question.

**The Chair:** Thank you very much, Ms Bradley, for coming before the committee today. We appreciate it.

**Ms Sylvia Bradley:** I stated that this is legislation from California and Minnesota. There are only 10 copies, so I didn't put it in the file. I'll leave it for—

**The Chair:** Fine. The clerk will get that. Thank you. That came up yesterday and we appreciate those copies.

#### REGISTERED NURSES' ASSOCIATION OF ONTARIO

**The Chair:** I next call upon the Registered Nurses' Association of Ontario. Welcome to the committee. Once you're settled, if you'd be good enough to introduce yourselves, then please go ahead.

**Dr Ruth Gallop:** I'm Dr Ruth Gallop from the faculty of nursing at the University of Toronto and a member of the RNAO. To my right is Pam Callahan, a member of the board, Shirley Broekstra, a member of the RNAO, and Margaret Watson, the interim executive director of the RNAO.

The RNAO is the professional voice for registered nurses in Ontario and lobbies government and other



organizations on issues that affect the wellbeing of nursing and client care. RNAO provides service to approximately 13,000 members and seeks opportunities to collaborate with individuals and groups of citizens, government and other health care organizations to influence changes in the health care system to meet the health needs of Ontario citizens.

The RNAO welcomes this opportunity to respond to the proposed amendments to the Regulated Health Professions Act which address the issue of sexual abuse of patients. This is a growing concern in health care today and we applaud the government's initiative in this direction and support the principles outlined in this bill.

I will comment on the definition of "sexual abuse." We fully support the inclusion of subsection 3(3) in the original Bill 100, as written, and feel that the definition presented is both pragmatic and easily understood. We do not support proposed government amendments to this section. We are concerned that adding to clause 3(3)(c), "behaviour or remarks of a sexual nature by the member towards the patient," the phrase "that are demeaning, seductive or exploitative" is confusing.

The issue is that sexual remarks should not be part of professional practice. Appropriate inquiry about sexual behaviour or sexual problems as part of the professional examination or consultation does not constitute sexual remarks. Further, we support the deletion of subsection 3(4).

Although sexual abuse is but one form of serious abuse, we do support highlighting sexual abuse as a means of reinforcing the seriousness of this problem. We fully support the inclusion of clause 3(3)(c), which designates sexual harassment within the realm of abuse, and applaud the recognition of the potential health consequences of such behaviour. It is desirable that this definition be in line with that set out in the Ontario Human Rights Code.

**Intervenor status:** We support in principle allowing for the possibility of third-party intervenors at a hearing and commend the government for identifying criteria for granting such status. However, we have some concerns regarding victims' requests for full party status. While we understand the derivation of this concern rests in the perceived inadequacy of charges or representation at hearings, we believe that it behooves the regulatory bodies to provide adequate self-policing, the essence of self-regulation. We support intervenor status, since it will allow opportunity for the victim to report on specific areas, such as impact.

None the less, we do feel it is important that any other intervenors on behalf of the victim must seek and obtain prior approval of the victim. In this way, the victim does not risk being further victimized by others who might wish to use the case to further their own agendas.

#### 1700

**Mandatory reporting:** We support mandatory reporting of all forms of sexual abuse, verbal and physical, as described in section 85.1. We agree with the proposed amendments to subsection 85.1(1); however, we question the necessity for the phrase "obtained in the course of

practising the profession," as this appears to be somewhat redundant.

As with child abuse, sexual abuse constitutes a violation of the trust which is implicit in caretaking relationships in which one person is responsible for the care and wellbeing of the other. We would highlight that at present the professional nurse is bound by the standards of practice to report professional misconduct, and that failure to report in itself is professional misconduct. It is hoped that this new legislation will highlight the need for registrants of all colleges to be conversant with their professional obligations and that sufficient education will be provided that registrants be sensitized to the issues.

We wish to emphasize that RNAO endorses mandatory reporting for all forms of abuse, including remarks of a sexual nature. We do not believe that this will create a groundswell of mischievous reporting. Historically, the health professions have worked very closely together and protected each other, even when there has been animosity among professions. In fact, although health professionals espouse advocating for patients, we have failed in this endeavour, so that advocacy for vulnerable groups has had to be legislated. This legislation may also provide some protection and legitimacy for nurses who work in the employ of physicians and observe abuse, since the consequence of reporting may be termination of employment or harassment. At the least, the legislation allows them to advocate for the client.

The RNAO has some concerns about suggestions that reports of behaviour or remarks of a sexual nature would receive a different process being directed immediately to remediation—for example, brief counselling or a meeting between the victim, the alleged abuser and a third party—since this may trivialize the abuse. We are concerned that the proposed plan for remediation will circumvent the normal hearing procedure.

We are pleased that under subsection 85.1(4), which deals with the exceptions to mandatory reporting, treating professionals are no longer given a limited exemption from the mandatory reporting requirement. Given the length of time in therapy required to change behaviours, if possible, the risk of continuing abuse remains high. Assurances of no further abusive behaviour by the abusing professional are meaningless.

We oppose the inclusion of clauses (c) and (d), including competency and incapacity within the bill. Both issues are fully addressed within the professional misconduct sections of Bill 43 and the inclusion of them through these amendments shifts the focus away from the central theme of Bill 100.

**Funding for treatment:** Funding for counselling should attend to the victim's wish for a non-physician, non-psychologist therapist, particularly if the abuser in the case was a member of one of these professions. RNAO supports the funding of necessary therapy and counselling for victims of abuse by health care providers. We would like clarification about the funding for victims when the therapy is provided by a professional currently covered by OHIP, such as a physician, or a private plan, such as a psychologist. Will colleges be required to reimburse OHIP or the private insurers rather than use public tax



revenues or insurance fees? This needs to be clarified so that all therapists or professionals participate on a level playing field.

The RNAO supports the amendment, subsection 73(5.1), concerning reinstatement, to use the guidelines of the task force of the College of Physicians and Surgeons for reinstatement.

Other issues: The core issue in sexual abuse is that the power differential between care provider and patient is a significant one which does not change over time. The question therefore becomes whether, once a nurse-patient relationship is established, for example, is it ever appropriate for a sexual relationship between the two to occur? We believe that in psychiatric and mental health settings the answer must be no. Other situations would best be addressed on an individual basis in the context of self-regulation, taking into account the circumstances involved. For example, with the increasingly chronic nature of illness, there will exist increased opportunities for long-term nurse-patient relationships to be established. It is questionable whether relationships of a sexual nature could appropriately occur within such a context.

Finally, increasingly nurses are required to supervise unregulated health practitioners, including nursing aides, psychiatric attendants and so forth. Nurses are being removed from direct care and into increased supervisory responsibility without authority. There is no mechanism for reporting of sexually abusive behaviour by these unregulated providers. This may place both the regulated health professional and the public in positions of jeopardy. Given the intent of the bill to protect the public, thought needs to be given to this issue.

This legislation suggests a role for professional organizations in assuring that appropriate mechanisms are developed to provide supports for registrants who report professional misconduct. This would include helping individuals who acknowledge their own misconduct to access the education, support and treatment they require. Additionally, professionals who report the misconduct of others might need support for themselves.

Bill 100 is commendable in its forthright approach towards stemming the problem of sexual abuse. It's a long-overdue piece of legislation which sets an appropriate standard of conduct for all health care providers in the province. It should serve as a deterrent to professionals who might otherwise abuse the privileged position of intimacy that being a health care provider allows.

Thank you and we'll be glad to answer any questions.

**The Chair:** Thank you very much. I'll turn first to the parliamentary assistant, who will answer some of the questions you raised.

**Mr Wessinger:** I'd just like to make it clear that the colleges will not be required to reimburse OHIP or the private insurers with respect to any of those services that are covered by—

**Dr Gallop:** Would that mean then that colleges which may be recommending therapists would tend to be encouraged to recommend a therapist who would not cost the individual colleges any fee?

**Mr Wessinger:** I note your concern there, but I think

the clear intention is to let the survivor choose who is the most appropriate person to deliver those services. That's certainly the intention of the legislation, to give that freedom to the survivor.

**The Chair:** Okay on that one? Thank you very much for coming before the committee.

#### ONTARIO HOSPITAL ASSOCIATION

**The Chair:** I'd like to call on the representatives from the Ontario Hospital Association. Welcome to the committee. If you would be good enough to introduce yourselves and then please go ahead with your submission.

**Mr Peter Harris:** My name is Peter Harris. I'm chair of the board of the Ontario Hospital Association. I'm joined today by Carolyn Shushelski, OHA director of legislation services.

Let me say at the outset, on behalf of OHA, that we are supportive of the efforts taken by the government to address the issue of sexual abuse of patients by members of regulated health professions. Hospitals employ or appoint many health professionals in the province and therefore will be directly affected by Bill 100. We are therefore pleased to have the opportunity to make this presentation to the standing committee.

OHA takes the issue of sexual abuse, and in fact abusive behaviour of any kind, very seriously. At the OHA October 1991 annual meeting, a resolution was passed which stated in part: "Be it resolved that the Ontario Hospital Association publicly endorse the philosophy of zero tolerance of sexual abuse within the hospitals of Ontario and develop guidelines for hospitals which, firstly, address the prevention of sexual abuse within hospitals and, secondly, provide recommended policies and procedures for responding to allegations of sexual impropriety and/or sexual abuse."

In May 1992, OHA established a task force to develop guidelines for hospitals related to all types of abuse of patients and staff. The guidelines were approved by the OHA board on November 6, 1993. These guidelines will provide direction and a framework that hospitals can adapt to their individual settings in developing or revising existing policies on abuse.

#### 1710

The guidelines address the following six areas of abuse: the abuse of patients by staff; the abuse of staff by patients; the abuse of patients by other patients; the abuse of staff by staff, that is, workplace harassment; the abuse of patients by visitors; and the abuse of staff by visitors.

Bill 100 proposes to amend the health professions code of the Regulated Health Professions Act, the RHPA, by adding a definition of sexual abuse which will apply to all regulated health professionals. We support such an amendment, because a single definition of sexual abuse would be a consistent guide for all regulated health professionals and for persons who employ such individuals.

However, we are opposed to an approach that would give the council of each college the authority, subject to the approval of the Lieutenant Governor in Council and with prior review by the minister, to make regulations

clarifying or modifying what constitutes sexual abuse of a patient by a member of the college. In our view, the potential effect of such a provision would result in an inconsistent approach to the definition of sexual abuse. Persons who operate hospitals and health professionals who are required to report instances of sexual abuse to regulatory colleges may have great difficulty determining when the duty to report arises if what constitutes sexual abuse could be defined differently by various colleges.

A single definition would promote a common understanding of what is sexual abuse and will encourage confidence in recognizing and reporting incidences of sexual abuse. Therefore, we support the proposed government amendment to Bill 100 which would delete the authority of a council of a college to make regulations modifying or interpreting what constitutes sexual abuse of a patient by a member.

Bill 100 will make sexual abuse an act of professional misconduct. We note that subsection 95(1) of the Regulated Health Professions Act provides that "Subject to the approval of the Lieutenant Governor in Council and with prior review by the minister, the council may make regulations" in respect of the following:

"24. defining professional misconduct for the purpose of clause 51(1)(c)."

Further, Bill 100 will permit the council to make regulations:

"25.1. designating acts of professional misconduct that must be reported."

Consistent with our previous comments, we support a single definition of sexual abuse for all regulated health professionals, as sexual abuse is professional misconduct. We are concerned that the proposed regulatory-making powers of the councils of the colleges "defining professional misconduct" and "designating acts of professional misconduct that must be reported" may permit the dilution, expansion or alteration of the definition of sexual abuse. OHA believes that there should be a single definition of sexual abuse and that it should be defined in the act.

We note that differences exist with respect to the duty to report regulated health professionals under the Public Hospitals Act and under the Regulated Health Professions Act as possibly amended by Bill 100. The inconsistencies relate to the following: the professionals to whom reports apply, the instances when the duty to report arises and the matters in respect of which reports are to be made.

The specific differences are as follows: The proposed government amendments to Bill 100 provide that a person who operates a facility where one or more members practise must file a report if the person has reasonable grounds to believe that a member, that is, any regulated health professional who practises at the facility, has sexually abused a patient. The report must be filed within 30 days after the obligation to report arises unless the reporter has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, in which case the report must be filed forthwith.

Further, Bill 100 requires a person who terminates the

employment or revokes, suspends or imposes restrictions on the privileges of a member, that is, a regulated health professional, for reasons of professional misconduct, incompetence or incapacity to file with the registrar, within 30 days after the termination, revocation, suspension, imposition or dissolution, a written report setting out the reasons for such action. As sexual abuse is professional misconduct, we assume that sexual abuse must also be reported under this provision.

However, section 33 of the Public Hospitals Act presently requires the administrator of a hospital to report to the College of Physicians and Surgeons of Ontario only when the application of a physician for appointment or reappointment to the medical staff is rejected; or when the privileges are restricted or cancelled by reason of his or her incompetence, negligence or misconduct; or where a physician voluntarily or involuntarily resigns from the medical staff of the hospital during the course of an investigation into his or her competence, negligence or conduct.

We recommend that the reporting requirements concerning regulated health professionals under the Regulated Health Professions Act and the Public Hospitals Act be consistent.

Physicians and dentists are initially appointed and then annually reappointed to the staff of the hospital. In the course of the appointment to the hospital, occasion may arise whereby the hospital must investigate allegations related to the conduct, performance or competence of any such member. Such an allegation could be related to the sexual abuse of a patient by a physician or a dentist.

In accordance with procedural fairness, the hospital would advise the member of the allegations and the member would be given an opportunity to respond. The matter may be investigated by the hospital and may be referred to the hospital medical advisory committee, which would make a recommendation to the board of the hospital. There may subsequently be a hearing before the board of the hospital. With respect to physicians, the Public Hospitals Act provides for a right of appeal of the hospital board decision to the hospital appeal board and then to the Divisional Court. Throughout the process, adherence to elements of procedural fairness is essential. Ultimately, a final decision will be made about whether the health professional has sexually abused the patient.

As noted previously, Bill 100 proposes that a person who operates a facility will have to make a report to the college in respect of a member where there are reasonable grounds to believe that the member has sexually abused a patient. The report will have to be made within 30 days, or forthwith if there are reasonable grounds to believe that the member of a regulated health profession will continue to sexually abuse the patient or will sexually abuse other patients.

The effect of this proposal is that the filing of such a report in most cases will likely occur before the member has had the opportunity to exhaust all aspects of procedural fairness required by the Public Hospitals Act and the common law. We believe this is the intention of the proposed legislation and would recommend that section 33 of the Public Hospitals Act be reviewed in this regard



and legislative reporting requirements by hospitals to colleges be made consistent.

Pursuant to the government amendments to Bill 100, sections 85.1, 85.2, 85.3 and 85.4 set out who, when, what and to whom instances of sexual abuse are to be reported. Section 85.5 sets out who, when, what and to whom instances of professional misconduct, incompetence or incapacity are to be reported.

Bill 100 proposes that paragraph 25.1 be added to subsection 95(1) to permit the councils of the various colleges to make regulations designating acts of professional misconduct which are to be reported.

What relationship, if any, does this provision have to the provisions in Bill 100 that relate to sexual abuse? What relationship does this provision have to the provisions in Bill 100 which deal with reporting of professional misconduct, incompetence and incapacity? This should be clarified.

Further, paragraph 25.1 does not specify who will be required to report. Is it intended that by regulation an operator of a facility could be required to report?

1720

The legislation itself should provide who is to report the matters on which a report is to be made and when the duty to report arises. OHA would not support a provision which would permit the various colleges to make regulations that would require hospitals to report. Rather, we would support that the legislation itself provide consistent, clear guidance in respect of reporting requirements.

Thank you for your consideration of our submission. We're prepared to answer any questions you may have.

**The Chair:** Thank you very much for your submission. Did the parliamentary assistant want to—

**Mr Wessenger:** Perhaps one question we could clarify. Reading the statute, it appears clear that it's the institution itself that has the obligation to report the sexual abuse under the provisions of the act. Second, I think it would be fair to say that I don't think a college, by regulation, could impose any obligation on a hospital to report in addition to—I think that would be not within the jurisdiction.

**The Chair:** Could I just ask one question? At the bottom of page 6 in the presentation you suggest that section 33 of the Public Hospitals Act be reviewed. To the parliamentary assistant, are there changes being proposed to the Public Hospitals Act to deal with some of these issues?

**Mr Wessenger:** Unfortunately, counsel today isn't involved in the Public Hospitals Act. It would require a response from—

**The Chair:** Okay. I take it these have been put forward in another place as well, or is this the first time you've made this recommendation?

**Mr Peter Harris:** I am not aware of any other place where this recommendation has been made.

**The Chair:** It is now so put forward.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Just in connection with the comments of the parliamentary assistant, am I to take it then that the answer to the

question that's asked on page 7 is yes? "Is it intended that by regulation an operator of a facility could be required to report?" From what you've just said, is that correct, that the answer to that is in the positive?

**Mr Wessenger:** Yes. It's the facility itself that has the obligation, and the act sets out that the facility can rely on the individual who has the responsibility for administering. In other words, the hospital administrator would be the one to in effect make the report on behalf of the facility.

**The Chair:** Any comments or further questions? Thank you very much for coming before the committee and for your presentation this afternoon.

#### PATIENTS' RIGHTS ASSOCIATION

**The Chair:** I ask the representatives from the Patients' Rights Association to come forward. Welcome to the committee. Please introduce yourselves and then go ahead with your presentation.

**Ms Peggy Pasternak:** My name is Peggy Pasternak and I'm a member of the Patients' Rights Association. To my right is Mary Margaret Steckle. She's the executive director, and she'll be happy to field any questions you might have in the second part of our talk.

On behalf of the Patients' Rights Association, I would like to thank the standing committee on social development for inviting us to present our views on Bill 100.

As you know, the PRA is a citizens' advocacy group comprising both consumers and survivors of the health care system, as well as professionals from a wide range of areas such as the health, legal and academic communities. It was founded in 1974, and it has relied solely on membership fees and private donations. We are committed to acting as patient advocates by assisting patients to have their grievances heard by working to bring about a more equitable complaint process and by educating the public about their rights.

Throughout the 10-year consultation process leading to the Regulated Health Professions Act, the PRA has expressed great concern about the ability of the self-regulating health professions to deal fairly with all types of misconduct. We remain convinced that health care consumers are entitled to an independent and impartial process which will deal with these matters. Our subsequent comments should be interpreted in light of those concerns.

The general public comes to the health care system with a number of expectations, namely, that as patients, they will be receiving help from an accredited health care professional to alleviate the pain that the professional is there to treat. Patients, sometimes naively—and sometimes wrongly, it seems—expect that treatment dispensed will be responsible, ethical and caring, and it can sometimes come as quite a shock to realize that the provider isn't thinking of providing care at all.

The PRA applauds the initiative of the current government to eliminate sexual abuse of patients. However, the proposed amendment to introduce the qualifying descriptors "demeaning," "seductive" or "exploitative" are difficult, if not impossible, to measure objectively.

Part of the problem of sexual abuse is that abusers



generally do not recognize or acknowledge that their behaviours or remarks might be perceived by others, including the patient, to be demeaning, seductive or exploitative. Moreover, staff and council members of various regulatory bodies have historically displayed the same lack of awareness about what constitutes sexual abuse.

We suggest that an additional element be introduced: that definitions of the words "demeaning," "seductive" and "exploitative" be drawn from the literature of the victims themselves and that these definitions be included in the legislation.

Additionally, provisions should be kept in place to allow review of these regulations in order to clarify and/or extend what constitutes sexual abuse of a patient and that continuous outcome monitoring be considered to measure the effectiveness of the enforcement of these regulations.

The PRA also strongly urges that recognition be given to the fact that other non-sexual forms of abuse exist as well, such as physical, verbal, emotional and psychological, the latter being just as damaging because it tears into the heart of a person's sense of self. Once again, survivor literature should be consulted. In the aftermath of such traumatic experiences, many victims, in order to understand their pain, have to write it out. There is much to be learned from these stories.

As to mandatory reporting, the PRA has always advocated that this be done. We are alarmed, however, that there has been some debate about deleting the clauses pertaining to mandatory reporting of practitioners who have committed an act of professional misconduct or are incompetent or are in some way incapacitated. Deleting these clauses would diminish the public's right to safe and competent health care. Moreover, we believe that not reporting abuse of practitioners is an act of professional misconduct in itself. It is important that the traditional attitude of non-involvement among doctors and other health professionals be changed. They have a responsibility to protect both the public and the reputation of their profession.

We would also like to remind the committee that there are other non-regulated professionals, some accredited by different institutions, some not, who do slip through the cracks of this legislation. For example, some lay psychoanalysts are still practising with immunity. It is imperative that they too meet standards for competence and adhere to codes of professional and ethical conduct.

In regard to the non-party status of complainants, the PRA has long advocated party status for all complainants at disciplinary hearings. The existing disciplinary process in fact discourages victims to come forward and seek redress. It has so often become a retraumatizing situation for many victims. It is sometimes an excruciatingly traumatic journey patients take from their initial request for help with a pain, through the trauma of abuse, and then yet again through the trauma of cross-examination and not being believed.

The PRA strongly supports the concept of funding for counselling. We further believe that the fund should be available to support access to those sources of help

chosen by the victims. For example, a victim should be able to get funding for transportation and child care to enable her to attend a self-help group if that is what she wants. Similarly, if a victim decides that art therapy is an appropriate medium for her or his situation, the funding should be made available for this.

It is unfortunate that we have to be here today to talk about the need to ensure the public's right to ethical and professional care, the need to ensure that breaches of trust and breaches of power will not be tolerated and the need to ensure that patients have a greater say in the type of treatment they receive. But until the need to ensure will no longer be necessary, the Patients' Rights Association remains committed to empowering patients to speak out and to demand that the health care system become responsible and accountable to the very people it is meant to serve.

**The Chair:** Thank you very much for your submission. Are there any questions at this time? Thank you very much for coming before the committee.

1730

JOSIE MacPHERSON

**The Chair:** Could I then call Ms Josie MacPherson. Welcome to the committee. The clerk is just handing out your submission, but please go ahead once you're ready.

**Ms Josie MacPherson:** Ladies and gentlemen, honourable members of Parliament, my reasons for addressing the standing committee on social development are twofold: Firstly, I wish to share my strong sentiments and information related to Bill 100, and secondly, I urge the Honourable Mr Charles Beer, as my member of Parliament, to assist me in my personal plight with medical abuse.

Throughout my presentation I will be referring to a number of documents which are in your possession. I have also provided the Chair of the standing committee with a full disclosure package, as well as a videotape which aired a year ago on television on a talk show entitled What's News. It is my wish that the videotape be viewed by the committee as further input into these matters, and my discussion will follow the sequence outlined.

I will begin by quoting from a letter which I wrote to my lawyer on October 26, 1993, which explains perfectly my situation:

"I have decided to terminate this matter between the doctor and myself as per our recent telephone conversations.

"I wish to take this opportunity to comment on my experience arising out of this matter.

"When I first came to you, I believed that initiating this was a viable way to seek redress for how I had been violated by the doctors. You informed me that if we were successful, the legal process would compensate me for my financial losses, but that the amount we could ask for was limited. Since I was interested in ethics, I could also proceed with the self-regulatory body, the College of Physicians and Surgeons.

"In process, I learned that the College of Physicians and Surgeons does not have a mandate for surgical

medical abuse and that few cases reach the disciplinary stage, with even fewer achieving any form of redress for the complainant. In my case, I worked diligently to provide the college investigator with my evidence. It did not matter that I pointed out lies and inaccuracies on the part of the members complained against.

"I proceeded to the Health Disciplines Board without the benefit of legal counsel, since I could not afford your fee of \$2,000 to attend with me. This was an emotionally draining experience and it proved futile. The doctor attended with his attorney and was afforded every courtesy. I, on the other hand, was reproached for bringing an advocate. Upon entry, she was told that she could not participate. I was not allowed admission of my evidence, which refuted false, unsubstantiated and highly slanderous comments made by the doctors and their lawyer...against my husband and I. It is noteworthy that I only became aware of these derogatory remarks at this late hour, well beyond the college process.

"The doctor, on the other hand, was allowed to pass around a photograph of another patient involving...a far worse condition than I had. He was also used as the medical expert in the case (clearly a conflict of interest).

"Last spring, in a meeting between you and I, I disclosed to you" that my family doctor "had been 'making comments and gestures of a sexual nature which were demeaning, seductive and exploitative' while I was his patient. I elaborated to say that he would repeatedly ask me if I was pregnant, even though he knew my husband worked out of town. He told me that my husband did not care about me because he was away so much and on another occasion asked me when my husband would be away next. This had an adverse effect on the quality of medical care that I was receiving, on my emotional wellbeing, on my marriage, and was highly unethical. I learned in process that he was sexually violating me. I also disclosed this in the college process and at the Health Disciplines Board. Even though the college has a mandate to take action against sexual abuse by doctors, my evidence was ignored. This raises the issue of mandatory reporting of sexual abuse as well as the penalty which should be incurred by a doctor who behaved as he did towards me.

"Finally there is the legal process. I have worked on this till I dropped, literally. This weekend, my back went into spasms and I became immobilized with pain. It was over. I have spent countless hours providing you with information and \$30,000 on medical/legal fees.

"I attended" Dr So-and-so "for a simple chalazion drainage and faced a confused, out of control ophthalmologist who said: 'I've already made 10 cuts and normally I just make two. I can't find it. There's nothing there. Now I'm worried about the bleeding.' He later dismissed me without analgesics or a follow-up appointment or a referral to repair my mutilated, deformed eyelid. It took over a dozen appointments with, for the most part, uncooperative, non-committal specialists, a year of my life, a trip to California, and a two-hour reconstructive operation, at my expense of over \$7,000, before my eyelid returned to a state that I could live with," and this is not sexual abuse? "This raises the issue

of a lack of disclosure and involvement among the medical community in cases of surgical abuse. It is my opinion that mandatory reporting of medical misconduct, incompetence and incapacitation is required if surgical victims are going to be assisted in the restoration of their health. It is noteworthy that" the family doctor "terminated our 'relationship' when I went to him with my damaged eye.

"The examination for discovery once again accommodated the doctor in question. It was held in Newmarket against my choice. My husband was asked to attend, resulting in a day's loss of pay, and then was not examined in order to facilitate" the doctor's schedule. "I was required to pay the extra mileage and added expense of your attending this process in Newmarket.

"Last week I asked you if you knew when I first came to you that I did not have a chance at succeeding in medical malpractice. Your response was that for every 100 people who become your firm's clients, 60 do not proceed beyond the investigatory phase; this costs the client \$4,000 to \$7,000. Out of the 40 that remain, 20 do not proceed beyond the pre-trial stage with an added cost of \$10,000 or greater. Of the 20 that remain, 10 settle out of court and the other 10 go to trial; this requires another \$10,000 to \$15,000. At trial, five win and five lose. Of the five that win, half are appealed by the doctors. The appeals take two years and no settlement is received before then. With every settlement there are legal fees which must be paid. A report by Robert Prichard in 1990, entitled *Liability and Compensation in Health Care*, showed that the number of medical victims compensated represents fewer than 10% of viable claims. This report recommended a no-fault system of compensation for victims.

"As soon as the paperwork is completed, my file will be closed, reduced to microfiche and in three years, shredded. All that will remain of this experience is the financial, emotional, and physical scars that my family and I will bear far beyond that time."

I refer you now to a second letter which I wrote on the same date to a college investigator. Again, I ask that you bear with me; I have tried to black out any names and if I have failed to black some out, please do so.

#### 1740

"In our telephone conversation of today you asked me what I hoped to gain from an apology/retraction from" the family doctor. "I do not feel that I need to qualify my reasons. The statements made by him in a letter to" the investigator at the college "and later in a letter to you are false, unsubstantiated, and of a highly character-defaming nature. They involve a medical opinion by a doctor whom I have never met. Furthermore, the initial statements made about me formed part of a file in a medical investigation. I did not have disclosure of these statements and thus lacked the opportunity to refute them with an expert medical opinion. It is my wish to have them appropriately retracted with an apology."

I refer you to a third letter written on that same date, this time to the Law Society of Upper Canada. It's with regard to the doctor's lawyer.



"I wish to comment on your letter dated September 9, 1993. I initially wrote to you asking for a retraction and apology from" the lawyer "for a false, unsubstantiated statement made by himself with regard to my wellbeing." The lawyer's "response indicated that he was quoting someone else. I still question his intent in providing a highly slanderous statement, out of context, without corroborating evidence in a medical investigation. To add insult to injury as a complainant, I did not have access to that statement. Furthermore, when I appealed the matter at the Health Disciplines Board, without the benefit of an attorney, the chair did not allow me admission of expert evidence proving that the statement was false."

I bring you now to the last paragraph.

"Your decision was for the law society to take no action in these matters. I disagree. You stated that you could not comment on the actions of the chair of the Health Disciplines Board since this was out of your jurisdiction. The chair of the Health Disciplines Board is a lawyer and as such is she not governed by the same body that self-regulates lawyers in Ontario? You further stated that the law society is not in a position to review or second-guess the findings of the judge."

I bring you now to the very last paragraph, on page 2.

"I decline your option to attend before a complaints commissioner at the Law Society since I am unable to attend with counsel and am aware that" the lawyer "is a lawyer and/or will attend with a lawyer. This negates this option for me, having experienced the unbalanced nature of the Health Disciplines Board hearing last year."

In these letters, ladies and gentlemen, members of Parliament, I wish to make two points. One point is that in this country we may as well say there is no medical malpractice for victims of surgical medical abuse. My second point is that the system of law is not equal for both parties. There is an obvious discrepancy between the two sides. Obviously and clearly, the doctor's side has a lot more rights than the patient-complainant's side.

I refer you now to my position on Bill 100, and that is found in the document that I have labelled D.

A year and a half ago, I began a support group for survivors of medical abuse. Medical abuse is rampant; sexual abuse is rampant. I recently reviewed Bill 100, a proposed act to amend the Regulated Health Professions Act, and the amendments proposed to it by the ministry. Bill 100 is not strong enough. The proposed amendments weaken it further. It omits many of the recommendations stated in the final report on sexual abuse of patients by doctors, November 1991. I will discuss some of the key areas which are of concern.

Full standing/intervenor status: Full legal representation is a must for complainants who go through the college process, often to no avail. The doctors and their defence team scrutinize every aspect of the complainant's medical-psychological past, including private journals and diaries. These personal documents are used to character-assassinate, ie, discredit the complainant. Without full legal representation, which includes the right to cross-examine and object, the complainant is set up to be revictimized. The prosecutor is the college lawyer and

looks after its own interests. Due to the harsh nature of the complaint process, many complainants refuse to go through it. Full party participation is not included in Bill 100.

Mandatory reporting: Initially, the ministry's initiative was one of zero tolerance for sexual abuse of patients by doctors. In the proposed amendments to Bill 100, the ministry's new position is to reduce the incidence of sexual abuse by medical practitioners. Comments of a sexual nature, asking patients on dates, flirting with, and psychologically manipulating patients would not be covered. These behaviours often precede more overt acts of sexual aggression.

The proposed amendments to Bill 100 diminish mandatory reporting by "giving treating professionals a limited exemption from the mandatory reporting requirement." A patient would in all likelihood confide in a treating professional about medical sexual abuse. Professionals should by law be required to report a colleague whom they believe has been or is sexually offending a patient. A good analogy is a teacher who by law is required to report suspected cases of child abuse. Historically, there has been a problem with disclosure, a non-involvement attitude, on the part of doctors.

Compensation fund for victims: Medical doctors found guilty of sexually violating their patients should be made financially accountable for their actions. This should include reimbursement of OHIP fees for services not properly rendered while sexually abusing. It is ludicrous that the taxpayer is burdened with this cost. Bill 100 does not include such a provision. Out-of-pocket fines should be incurred by offending doctors and the same should be included in a compensation fund for victims. Fines are not being imposed by the colleges for guilty members.

Bill 100 provides compensation to the victim in the form of a maximum of \$10,000 to be used for psychiatric counselling. This is grossly inadequate. For victims, there is a grave loss of trust with the medical profession. The fund should entitle a survivor to full compensation for losses incurred as a result of the offensive act, including therapy of choice.

Physicians' commitment to the patient: Victims of sexual abuse by doctors sustain irreparable damage. The majority of offending doctors go on practising. A few of the perpetrators receive temporary suspensions of their licences. The Canadian Medical Protective Association, the insurance company for doctors, pays all of their legal fees, while victims must pay expensive legal fees if they proceed with civil action. This in itself is revictimizing.

There is a need to educate and prevent further abuse. This can only be accomplished if patients, as well as doctors, lawyers, and judges become informed about the rights of patients. The final report recommends the creation of a patient pamphlet as well as a poster which would be visible in every medical office and emergency room. This information would empower and inform the patient about the appropriate boundaries for doctor-patient relationships and how to proceed if they are transgressed. Bill 100 does not include any provision for this.

As survivors of medical abuse, it is our firm belief that concrete change is essential if patients are going to be



protected. We feel that Bill 100, amended to include all of the issues which I have discussed, must be passed as expediently as possible to become law.

I refer you now to document G, which is the Prichard report. This is taken—

**The Chair:** I'm sorry. How many more do you have? I apologize, but it's just that we have a lot of people who are also going to be making their presentations and—

**Ms MacPherson:** How much more time do I have?

**The Chair:** I'm afraid we are over the 15 minutes, but if there are one or two others things you wanted to put on the record—

**Ms MacPherson:** I will leave that with you then and you can look through it at your own discretion. I'm sorry I've lost track of time in that I've used up my 15 minutes so quickly.

1750

**The Chair:** That's all right. If there is perhaps a closing document—

**Ms MacPherson:** There is one other thing I would like to highlight and I'll refer you to that. I would like to highlight point 4, which is H. This is taken from June 1993, volume 2, issue 5 of the Medical Times, and I would like to quote a couple of lines from it. If we go to the end of the second column, it says:

"Despite such concessions, government remains unresponsive to the group's insistence that mandatory reporting of sexual impropriety be replaced by voluntary reporting and a duty to intervene.

"While government has agreed to drop the provision requiring health professionals to report instances of professional incompetence or incapacity, the ministry has refused to accept our arguments against mandatory reporting of sexual impropriety."

I feel it is essential that the mandatory reporting of medical incompetence, medical incapacity and medical misconduct which is in Bill 100 not be dropped. I urge you not to drop it. It is the only safeguard in that bill which will protect victims of surgical sexual abuse, and violating a woman's body is sexual abuse.

In closing, I just want to refer you to the very last page, the bottom paragraph. I want to read to you the survivor's mandate.

"Survivors of Medical Abuse firmly believes that patients have a right to be treated with respect and with integrity by their health care professionals.

"We feel that we should have access to copies of our medical records.

"We feel that we should have input and a say as to the course of treatment for our bodies, and above all we feel that if a patient is violated, they should have recourse through our legal process, and if there isn't one in place that works, one should be established."

**The Chair:** Thank you very much for your presentation and also for a number of other documents that you have provided and which we will be able to look at.

I might just say, as the first part of your presentation was directed to me, that I will be in touch with you so we can go over this in more detail.

**Ms MacPherson:** Thank you very much.

**The Chair:** Thank you again for coming before the committee.

**Ms MacPherson:** Are there any questions, or not at this time?

**Mr Jackson:** There are, but we've run out of time.

**The Chair:** Frankly, your presentation was the more valuable for getting more of it on the record, so we thank you for that.

**Ms MacPherson:** Thank you for your time.

#### METRO ACTION COMMITTEE ON VIOLENCE AGAINST WOMEN

**The Chair:** I call our next witness, the Metro Action Committee on Violence Against Women. Welcome to the committee, and please go ahead.

**Ms Susan McCrae Vander Voet:** Thank you very much. You must get very tired of listening. That's what I've been sitting here thinking.

**The Chair:** No.

**Ms McCrae Vander Voet:** I'll try to be brief and to the point. I don't have a package of information to give you; it's not in a form that I could do so. But I will see that one gets forwarded to the committee.

I just wanted to say that Metrac, the Metro action committee, is a non-profit organization whose mandate is to address issues of violence against women and children and to promote the rights of women and children to live free from violence and the threat of violence in all its forms. Metrac will be celebrating its 10th anniversary next year.

In the course of our work, we encounter many survivors of sexual abuse by professionals in the health field. It is their experiences of the abuse and of the investigative and disciplinary processes within health care regulatory bodies which form the basis of our presentation and our recommendations. In fact, Metrac's work over several years led to the establishment and conduct of the independent Task Force on Sexual Abuse of Patients, which reported to the College of Physicians and Surgeons of Ontario. The cutting-edge work by that task force informs us substantially, and I know it does this committee.

In all of your deliberations about this bill, I would urge you to keep in mind three overriding things. First, it is a privilege to practise in a health care profession in this country, not a right. Second, survivors-complainants are the only injured party in a sexual abuse hearing, not the professional, not the college and not the association. Third, there is no evidence anywhere that I've been able to find that a psychiatrist, a psychologist, a counsellor or even a diviner has the tools to predict successfully when a person will or will not commit an act of sexual abuse.

We commend the government of Ontario for the initiative it has taken in bringing forward the legislation. It represents a step forward towards a badly needed campaign to curb violence against women and children. In this year alone we've had two landmark reports which have described in detail the extent of violence and the incredible level of tolerance which we experience in this

country. The effort which Bill 100 represents to regulate health professionals, to stop and to prevent sexual abuse by their members will, we hope, signal a powerful and privileged group in our society that the abuse of this power and privilege for personal sexual gratification will no longer be tolerated.

Metrac supports the objectives of Bill 100 and many of the components of Bill 100. The issues we raise in relation to the bill reflect our concerns to strengthen the legislation and to maintain, rather than weaken, parts of it as they have been tabled. Some of our recommendations therefore will urge you to maintain what is already in Bill 100 rather than weaken it by adopting proposed amendments. Other recommendations are to add to the bill—for example, a preamble—measures which will strengthen it as a tool for removing the practice privileges of offending professionals who breach a public trust, their professional oath and their fiduciary duty.

The issues and recommendations which we are making today are as follows:

There is a serious need for a preamble to Bill 100. We recommend adoption and inclusion of the preamble proposed by the National Association of Women and the Law or its adapted form proposed by the Out of Patients Advocacy Network and supported by many other women's groups and coalitions.

We urge you to add to the definition of "sexual abuse" female genital mutilation and other than that to leave the definition as it currently stands in the legislation. When Vayisuva Keyi appears before you this evening, she will be more precise and compelling about what is needed in this regard.

**Mandatory reporting:** It is crucial that this committee leave the mandatory reporting requirements in this legislation as they are, including the mandatory reporting of remarks and behaviours of a sexual nature, without exception.

**Standing and paid legal representation for complainants:** In keeping with practices in other administrative tribunals, such as the judicial council and the Human Rights Commission, full party standing for complainants must be granted, along with payment for legal representation for complainants.

**Incompetence rulings in cases of sexual abuse:** We strongly recommend that when a medical professional is found to be sexually abusive, he must be found to be incompetent as well as guilty of professional misconduct. We understand the compelling financial reasons which the Canadian Medical Protective Association may have for opposing that. However, that's what we'd like to see.

**Compensation for survivors:** In view of the clear conflict of interest which colleges and other regulatory bodies of the health professions have in administering funds to survivors, the distribution of which depends upon their own vigorous investigation and prosecution of sexual abuse complaints against their own members, we recommend that the minister, upon proclamation of this bill, refer the matter of establishing an independent body to administer the funds to the advisory council for consultation with the wider community of interest and for

recommendation to the minister.

Finally, Bill 100 and the ultimate test for the professions: We regard Bill 100 as a test for the health care professions regarding whether they are able to self-regulate where a serious breach of public trust and fiduciary duty by a sexually abusing member calls that ability into question. We recommend careful monitoring of all cases and complaints, with or without findings, which are brought to all RHPA regulatory bodies in order to assess the success of self-regulation in this area. That's all I have to say.

**The Chair:** Thank you very much. Are there any questions at this time?

**Ms McCrae Vander Voet:** There are no questions?

**The Chair:** No. Thank you very much for coming before the committee this afternoon.

Could I then call Ms Sylvia de Persis. If she is not here, Ms Joyce Emerson.

1800

SUSANNA KLASSEN

**The Chair:** Is Ms Susanna Klassen here? Would you be good enough to come forward. While you're doing that, I would just say to members that following Ms Klassen's presentation we will have a short break and then reconvene with Ms Jane Doe. Ms Klassen, welcome to the committee. Please go ahead.

**Mrs Haslam:** I'd like some clarification. Since it is only 6 o'clock and you're indicating that we would skip over the 6 pm and the 6:15, are you leaving time for them to appear before the committee at a later time?

**The Chair:** If they appear, they will be able to come.

**Mrs Haslam:** It's just that it's only 6 o'clock, and five minutes late should not be held against Ms de Persis.

**The Chair:** The break will be for the purpose of briefly having some nutrition.

**Mrs Haslam:** I understand that. It's just that you said we would continue with Jane Doe. I wanted to be clear that we were not eliminating the previous two, since the time slots were very clear here.

**The Chair:** Thank you. Please go ahead.

**Ms Susanna Klassen:** I would like to thank this committee for this opportunity to express my opinion and my concerns regarding Bill 100. My comments arise from some work that I did on my university courses, when I studied the whole subject of transference love. I want to speak to mandatory reporting and to the reference to psychotherapy, how this bill could apply to psychotherapy.

I support Bill 100 in that it does not define patient status. My position with regard to the phenomenon of sexual abuse within professional-patient relationships is that there is an urgent need to correct the problem with high-profile public and professional educational programs. I believe that it is never acceptable for a sexual relationship to develop within the professional-patient relationship.

Having said that, I will disagree with the requirement of mandatory reporting. As well, I will argue that it is essential that Bill 100 ensure flexibility in all post-



professional-patient situations, including post-psychotherapy and post-psychoanalytic relationships.

The recommendations I am making are that mandatory reporting be deleted from Bill 100, that the decision not to include a definition of "patient" be upheld by this committee and that Bill 100 ensure that individual situations will determine professional-patient status in all cases, including psychotherapy and psychoanalysis.

As a standing committee on social development, it is your responsibility to consider the significance of Bill 100 within the context of the existing social structure. We are living in an age that is characterized by unprecedented and rapid change. All institutions and professions are being examined and questioned and will increasingly be required to be accountable to the individuals they seek to serve and to the larger society.

Some of the forces shaping our social structure are the equal rights and human rights movement, feminism, the sexual revolution and the ecology movement. A common theme in all of these movements is the concept of empowerment, equality and respect for the value and uniqueness of the individual in relation to others and the environment.

**Mandatory reporting:** The requirement of mandatory reporting is at variance with the progressive social development initiated by these social forces. Mandatory reporting disempowers patients and violates their human right to decide for themselves how to respond to their own experience. This requirement also places the professional in a position of power that is paternalistic and intrusive to the patient. I have expanded on this in a paper that examines the Task Force on Sexual Abuse of Patients. It's in appendix 1, after the yellow paper. I'd like to encourage you to read that.

Feminism, the equal rights movement and the empowerment movement have laboured to achieve an egalitarian society. The right to make choices in relation to one's own life experience is a fundamental principle in a democratic society. The feminist movement was based upon achieving this right for women as well as men. Patients are now actively working to achieve these rights within a professional-patient relationship. The Ministry of Health has endorsed empowerment of patients as a basic tenet of the mental health reform process.

At a recent conference in Toronto the keynote speaker, Professor Kilean—and there's information about how to get his tape; that's all I had—identified an emerging social structure as post-patriarchal. The individual within this culture is concerned with restoring human values that were lost during an industrial period which relied heavily upon science and technology to establish truth. He identified the ingredients necessary for further development of this post-patriarchal culture as being concerned with human rights, self-regulation, negotiation, reciprocity, cooperation and partnership.

In light of this, I believe the decision to report a professional should be left to the patient who believes that he or she has been sexually abused. It would be more productive to create legislation that would facilitate the process of seeking redress in a manner that would be educative and therapeutic for both parties, rather than

excessively punitive. From the previous reports that you heard, it's not easy for a patient, and that I think is what should change. It should be possible for patients to seek redress with less pain and without being retraumatized.

**Patient status and psychotherapy:** My rationale for advocating flexibility in defining patient status and extending this flexibility to the psychotherapeutic and psychoanalytic relationship is well documented in appendix 3. This is a paper I wrote; I did research on the whole concept of transference love and the practice that comes from it.

The lifetime ban on relationships as proposed by the college of physicians and surgeons in the case of psychotherapy or psychoanalysis is, in my opinion, a violation of human rights. An imposed ban robs the patient and the professional of a fundamental right within a democratic society, which is to choose their relationships.

A study conducted to determine the prevalence of psychiatrist-patient sexual contact indicated that 65% of the respondents had been in love with their patients and that 92% believed that their patients were in love with them. These findings point to the fact that the state of being in love is a significant factor in the occurrence of sexual relationships that result from a psychotherapeutic relationship. It is debatable whether such sexual relationships are in fact abusive. Sexual attraction and falling in love cannot be legislated, nor are such phenomena restricted to certain physical environments. It would be more productive to examine and revise existing theories and practices that view sexual attraction and falling in love as a therapeutic tool.

I believe that emerging professional literature on transference love indicates that a paradigm shift is already occurring. This will radically alter theory and practice as they relate to patients and professionals who fall in love in a therapeutic situation. Hopefully the result will be a recognition that the state of being in love is not an appropriate therapeutic tool.

Until this happens, it is of crucial importance that the door is left open for individuals who fall in love in a therapeutic situation to enter into a full sexual relationship if that is determined to be in their own best interest. To render both professional and patient as helpless and vulnerable for the rest of their lives because they were engaged in a process that would illuminate their unique transference phenomenon can be a serious distortion of their reality.

For that reason, I believe it is dangerous to allow disciplining bodies to set standards and guidelines that go beyond the professional-patient relationship and extend into the personal private lives of individuals. It would be more productive to approach this problem of sexual abuse with an open, inquiring mind in order to avoid the possibility of creating a new victim population.

It is a well-known fact that there are successful marriage relationships that develop post-therapy. It is also recognized that many relationships between a professional and a former patient become traumatic only after the relationship has dissolved. This kind of trauma is common to most situations when relationships dissolve, especially if it was a meaningful relationship. A recent



publication details the experience of a patient who claims she was traumatized because she was deprived of a sexual and friendship relationship with her former therapist. That's a book that has just been published this past October.

In conclusion, I would like to emphasize that it is very important to distinguish between actual sexual abuse that occurs as a result of psychopathology and sexual involvement that is the result of two people falling in love. I do not believe that professional bodies and their governing bodies are presently equipped to respond adequately to this difference. Therefore, it is your responsibility as a committee to ensure that the legislation that is derived from Bill 100 is flexible and sensitive to diverse human need and that it reflects the progressive social movements that encourage the building of an egalitarian society in which individuals are encouraged towards personal empowerment.

1810

**The Chair:** Thank you very much for your submission and also for the attachments you've brought. Ms Haeck, you had a question.

**Ms Christel Haeck (St Catharines-Brock):** I guess there are many questions I have for you, and we don't have enough time today to delve into them all, but I did want to raise with you a question I have raised with a number of other people who have come before us. It relates to the mandatory reporting issue, particularly in the whole process of establishing a trend. I understand that, from your point of view, you may not view, particularly in the case of psychotherapy or psychoanalysis, that some incident of sexual abuse may in fact have occurred.

Shall we use another RHPA professional body? If you went to your family practitioner or to a dentist or a massage therapist and someone else was fondled in a way they did not consider to be professionally appropriate but did not feel they had the strength within themselves to report this to the college themselves but did in fact mention it to, say, the nurse in the front office and, as a result of this, the nurse—because we have in fact put forward mandatory reporting and the nurse would report this and there might be other incidents that would occur. You would have at least established a pattern up until the point where there would be an individual who had the inner strength to really go through this process. You have outlined that it is a difficult process, but there is this process. Would you not believe it is important to have that sort of track record to be able to say that someone has in fact done this on several other occasions and that really and truly this is a person who probably should be removed from their profession?

**Ms Klassen:** It's a difficult question. Yes, I definitely believe there has to be accountability, but from the perspective that I'm coming from, if there are three or four people who have had the similar experience with the same person and we had established a social structure where these kinds of people could seek redress, they wouldn't need to have someone else reporting for them. My main point is that it's an empowering process for that person to go through to deal with it themselves, to make the decision themselves that, "What this person did to me

has to be reported, has to be dealt with," rather than someone else coming in and saying, "I'm going to do it for you."

**Ms Haeck:** I don't know that anyone else is going to do it for you. That person has reported it to someone but realizes—in my own office, as an MPP, I encounter a range of constituents who are very concerned about lawyers, occasionally people in the medical profession, and they realize that however strongly they may personally feel about their issue, they may not have the money, they may not have the time and they may not have the inner fortitude to deal with the structure that's there, but they feel they have to tell someone.

**Ms Klassen:** But that's what I'm saying to you: It is your responsibility to see to it that we establish a social structure that will make it possible for people to do this reporting themselves and not experience all this retraumatization.

**Ms Haeck:** Okay, thank you very much.

**The Chair:** Thank you very much for coming before the committee and for the background material you've also left with your presentation.

I believe Ms Emerson is here. I think at this point I would suggest we take a brief recess, if that's all right, and come back at 6:30.

**Mr Stephen Owens (Scarborough Centre):** No.

**The Chair:** Did I hear "No"? If we could come back at 6:30 and then if we could do this: Ms Jane Doe has requested to appear before the committee but not to be televised. It would be easiest for us if we could begin with her and then move to Ms Emerson. If Ms de Persis has joined us, we can then hear from her as well and then go on to Ms Irene Crews and continue with the schedule. So if that is agreeable to everyone, we'll break. Let's make it 20 minutes, just to make sure we can do the things we need to do, and be back here at 6:35, at which point we'll hear first from Ms Jane Doe. Is that agreeable to members of the committee? Yes?

**Mrs Haslam:** Are we closing the entire—

**The Chair:** No. This room will stay open.

**Mrs Haslam:** Just the televised?

**The Chair:** Oh, I'm sorry. With respect to Ms Doe, everything will be open—I believe that is the arrangement—except that it will not be televised.

**Mrs Haslam:** Fine. Thank you.

**The Chair:** We stand adjourned then until 25 to 7.

*The committee recessed from 1816 to 1845.*

**The Vice-Chair:** Good afternoon, ladies and gentlemen, members. The standing committee on social development, holding hearings on Bill 100, An Act to amend the Regulated Health Professions Act, 1991, is now in session.

We were advised prior to adjournment that Jane Doe would be appearing first. However, she is unable to appear tonight and will be appearing before the committee at a future date.

Sylvia de Persis

**The Vice-Chair:** The next presenter then will be

Sylvia de Persis, who has requested that we proceed without TV for her presentation. Can that be changed at this time?

**Interjection:** The person now presenting?

**The Vice-Chair:** Yes, this next person is without TV. Just a moment, please.

It's changed. Would you like to introduce yourself and then proceed with your presentation. Welcome.

**Ms Sylvia de Persis:** I am Sylvia de Persis. Naturally, I want to speak about sexual abuse and Bill 100. It is my conviction, ladies and gentlemen, that the definition of "sexual abuse" in Bill 100 should specifically include unnecessary surgical procedures that affect the sexuality of the victim.

Through a brief description of my experience with such procedures, I hope to make my conclusions more accessible to your understanding; that is, I intend to underline our goal for zero tolerance of medical sexual abuse by drawing attention to the fact that surgical abuse of a woman's sexuality should not be exempt from Bill 100.

As a consequence of interference with my medical records and my medical care by a professional institution that was interested in disempowering my allegations of theft and sexual harassment, I was coerced into unnecessary procedures at a most vulnerable time. I was expecting the birth of my first child, and the events that led to the surgical procedures consisted of merciless pressure justified by false information.

I had an ovarian cyst that was large but not unusual in obstetrics, and I was forced to act on the assumption that the cyst was dangerous and that it could damage my baby and/or me. I was flatly refused the right to consider alternative methods of dealing with the cyst, such as draining the cyst, and I was consistently told that the cyst had to be removed by surgery, while I consistently maintained that the cyst was not the reason that I was dealing with obstetricians and that I did not want to concern myself with it until after my baby was safely delivered. I was subjected to severe pressure to speak with a psychiatrist about it, which I refused to do.

The cyst was not blocking the birth canal and therefore vaginal delivery was viable, and that is what I wanted. The doctor agreed, but instead of concentrating on the birth, he concentrated on the event that an emergency would be necessitated and therefore returned his attention to the concern with this cyst and how major abdominal surgery would have to take place to deal with the cyst at a time when I would be dealing with a newborn baby.

This went on and on and on and a severe process of coercion resulted from the impasse. I had been assured throughout my prenatal care that the baby was doing very well and that the foetus was larger than average. But now I was told the baby was growth-retarded, that the level of amniotic fluid was dangerously low and that my baby's life was in danger. This false information justified intolerable pressure and the decision that I should be induced. I didn't want to be induced because I was educated enough about the practice of induction to fear it.

1850

The intimidation tactics that I experienced were effective. They tormented me with guilt and with fear. I was told that the growth retardation of the baby was related to my inability to totally quit smoking during my pregnancy. They stated that I would be responsible for my baby's death if I did not make the decision to have an induction. I suspected that the induction would lead to an emergency, and so we went full circle back to the beginning. My position was that I didn't want to deal with this cyst, and their position was that they couldn't give me a bikini-line Caesarean should an emergency result because they didn't want to break the cyst. They felt that the cyst was probably dangerous, had noxious fluids in it, and that if this fluid spilled, it would affect me, it could affect the baby etc. I kept insisting that the cyst wasn't harming me so far, that the baby was due any day and that I should have the bikini-line Caesarean and find a way of dealing with the cyst afterwards. They alienated my husband's and my parents' support by telling them that I was basically being irresponsible and that the baby was in danger.

Finally, under extreme pressure, when I did go to another hospital and had a second opinion, I was told that the baby was fine and the amniotic fluid was fine. To do this, I had to say that I was from out of town and that I was feeling abnormal pressures in my abdomen that concerned me, so as not to allow the other hospital to interfere. But because my husband started to rage and insult me about being paranoid and jeopardizing the life of my baby and because all the nurses were coached to cooperate with begging and pleading and because I couldn't handle any more at all—I just wanted it to be over; I was extremely traumatized—I agreed to induction.

As I was pushed into the room and while I was being hooked up to the monitor and the induction fluid, I was weeping openly and I kept repeating that I didn't want to do this. I was left entirely without responsible care in the induction process for three hours in spite of obvious trauma. Only my husband was there and the tension between us was at that point formidable.

When the pain started, it increased rapidly to dramatic degrees. I began to panic because the pain became intolerable in my back but didn't move to the front where it was supposed to. I was in a lot of anguish and I started to cry out for some kind of pain relief. When the doctor came in, he examined me and discovered that I hadn't dilated at all after three hours and pain that couldn't be dealt with any more. Then the nurse who was with him noticed the monitor and started to express extreme alarm, and the next thing I knew I was being told that the baby's heartbeat had stopped. Booming voices basically announced an emergency and I was rushed into surgery.

We had agreed firmly that should an emergency occur, I would receive local anaesthetic. This was ignored, so I was unconscious throughout it. My husband's presence was not allowed. During the surgery, a fallopian tube was removed, although the fallopian tube, as far as the medical records state, was not affected. Also, the ovary was removed, which I guess was affected because the cyst was large. And of course the baby was born.



The baby was totally fine. He was not growth-retarded. The paediatrician who examined the baby personally told me later that he was perfect, that nothing was wrong. He was an exceptionally tall baby and his weight was average. He was beautiful and without defect. My condition, however, was the opposite. I was in severe pain regardless of the fact that I was drugged into a state of stupor, and most devastating to me was the fact that the cyst broke anyway, so the surgery had been done in vain. The reason for subjecting me to this abdominal surgery was defeated as the fluid from the cyst had spilled into my internal organs.

Furthermore, I couldn't be told the results of this, whether the fluid was in fact poisonous and whether I was in danger, for three days because they had to do tests on it. Meanwhile, I was getting all kinds of medication etc.

The nurses started to make observations concerning the care of my baby and didn't seem to take into account that I was extremely traumatized. They made judgements such as that I didn't seem to care too much about the baby.

When information arrived about the cyst finally, it was just as I had expected. There was nothing harmful about the cyst. I could have had a perfectly normal delivery that would have resulted in a healthy baby and a healthy mother, but I was defeated, alone, in severe pain, and the consequences to my body traumatized me greatly.

None the less, I was expected to act grateful and happy. When I was honest instead, I was judged as having postnatal depression. This ended up in my being restrained—that is, tied down to my maternity bed with leather straps—assaulted with medication that they normally use for psychotics, although I had no background in psychiatric care, and I was made unconscious.

I'm sorry I'm faltering; this is very upsetting to me.

When I woke up in the psychiatric ward, I was still in restraints and under observation, and my baby wasn't with me. I believed that I had been brain-damaged, and the cruelty of the environment terrified me into absolutely cooperative silence. It wasn't until much later, during preparation for a litigation process when I obtained copies of my medical record, that I discovered all the lies that are on my record and that my fallopian tube was removed during surgery.

Ladies and gentlemen, I want to ask that you consider that this case is not only about medical malpractice and unlawful confinement under the Mental Health Act; I think it is about corruption, collusion and sexual abuse. I am here to urge you to consider the definition of "sexual abuse" in Bill 100 as one that must include surgical procedures. The act of having a baby is an engagement of a woman's sexuality, and a woman's reproductive system is her sex. Violence done to the sexual system by surgery is not less important than the traditionally understood forms of sexual abuse. It is vital that we take action to have more protection from sexual abuse through surgery, because the damage that results is permanent in the full sense of the word, and the psychological damage can be profoundly debilitating.

When we talk about sexual harassment today, we are

sophisticated enough to understand that its meaning is not limited to an explicit act of sexual pressure intended to solicit sexual gratification. Before attention was given to this serious matter in the judicial system, many cases of sexual harassment were trivialized and the victim was silenced by the fact that her complaint was treated more like an embarrassing indiscretion or like gossip rather than a serious allegation worthy of respect and attention.

Because serious attention in the disciplinary bodies is not given to the fact of sexual abuse through surgical procedures, some doctors refuse to even acknowledge that it happens. The so-called feelings of victims are represented as deficiencies, because all a doctor has to do is to present reasonable evidence for his position that he believed he was doing the right thing to defend himself against litigation based on malpractice. Therefore, the experience of the victim who is sexually abused by surgical procedures is represented as being overreactive and, as in previous times with sexual harassment, the victim is put to shame and accused of lacking appreciation for the doctor's position.

#### 1900

It is highly important that a deterrent be established. Doctors who are conscious of the fact that they can be disciplined for sexual abuse through their surgical procedures would naturally be less confident about taking such liberties.

Since we have finally and rightfully accepted that a woman can be sexually harassed by comments, innuendo etc, how can we ignore that a woman can be sexually offended by surgical procedures performed on her sexual parts? Many women are in fact harassed by doctors to make decisions that they cannot resist because of intimidation. If these women and these doctors would be aware of a definition of sexual abuse that includes surgical procedures, a lot of anguish might be avoided.

The vulnerability of pregnant women to surgical procedures that attack the sexual system must be compensated for openly and fairly. Let us not pretend to a policy of zero tolerance of sexual abuse while this issue is ignored. Let us instead be sincere and recognize that if qualifications are made and gradients of severity are established, the sexual abuse that happens under a knife is the most severe form.

**The Vice-Chair:** Is there a question at this time? Thank you very much for your presentation. We'll leave the TV off for a moment.

JOYCE EMERSON

**The Vice-Chair:** The next presenter is Joyce Emerson. Would you introduce yourself, please, and proceed with your presentation.

Just a moment, please. Did you wish to speak at this time, Mr White and Mr Owens?

**Mr Owens:** After the presentation.

**The Vice-Chair:** Proceed, please.

**Ms Joyce Emerson:** I am Joyce Emerson. I am a coordinator and a therapist of abused women and incest survivors. I work from the Oshawa YWCA, coordinating the Apple House project. I hurriedly prepared for this meeting when I heard about it. I was very concerned that



I wasn't informed about it ahead of time, as were many of my colleagues. It's my hope that you will extend the period of this proceeding so that many more of my colleagues can come forward. They're very concerned about victims' rights.

I believe each of you have a page, and I'll add to that as I go.

Sexual victimization of patient-clients by health professionals is a serious abuse of power. An educated professional benefits from ascribed power within a community. Previously abused or victimized persons are especially vulnerable to further exploitation and/or abuse. They depend on the professional to set the boundaries in a relationship based on trust. They assume the power of the professional will be used in a healing and professional manner. As a result of basic trust in what is societally known as a professional mandate to heal, patient-clients are ill equipped to challenge what is proffered by a professional as part of the healing process.

Furthermore, patient-clients may attribute benevolence to subtle or overt messages or actions implying that they hold special status for the professional, even when professional and personal boundaries become blurred. This is the ultimate betrayal of trust. They have depended on the professional to protect them in this relationship of trust, assuming the professional would never exploit them for his or her own purposes.

Furthermore, sexual victimization by health professionals represents a breach of public trust in professional endeavours. The public, the client-patient base of the professional group, lose the ability to determine who will be really therapeutic or helpful to them in that profession. As a result, all professionals are tainted by the actions of certain abusive members of the profession. Public trust can only be restored when immediate, stringent actions are taken to re-establish professional standards.

Our concerns and comments: Based on the abuse of power existent when a health professional sexually abuses a client-patient, we have the following concerns about the changes proposed for Bill 100:

Section 6, section 36 of schedule 2: A concern about the wording of this section is that current research and practice models are inefficient and sometimes incapable of predicting whether an abuser will re-offend. Therefore, in the interests of protecting vulnerable members of the public, who may be unaware of allegations against a professional, it would seem incongruous to reinstate an offending health practitioner. Reinstating a discredited health practitioner would be seen as empowering him or her to re-abuse. Further, the public may interpret reinstatement as collusion among powerful professionals, resulting in a loss of professional integrity.

Subsection 11(3) of the bill: Revoking for certain kinds of sexual abuse needs to be clarified. The action of the professional should not be the only determining factor in the application of penalties; the impact on the patient-client and the degree of breach of trust needs to be given prime importance. In addition, the impact on the public including the devaluing of the profession needs to be included in the decision to revoke.

Section 18 of the bill, section 85.7 of the code: Regarding funding for treating sexually abused patients, the choice of the treatment to be funded needs to be determined by the patient-clients without restrictions or controls by the medical/professional colleges. The patient-client may choose the type of treatment, and if long-term treatment is required, funding needs to be provided for the full duration.

Section 51 of schedule 2: Under "Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following," please add "vi. sexually seductive or suggestive behaviours."

Section 72 of schedule 2, (3)(b): There is the question of how many times can a person re-apply, and should he or she be allowed to re-apply after having a revocation for sexual abuse of a patient?

Section 73 of schedule 2: What are prescribed conditions? If "prescribed conditions" refers to the likelihood of a member re-abusing, the question is how can prediction regarding abuse and re-abuse be made with any certainty? Who determines the degree of certainty? Does an abused client-patient have any say in determining this decision?

I might add, are health practitioners reinstated if they've been revoked for other reasons? Any reinstatement needs to be reviewed not only by the member's peers but also by victims' services and advocates.

Section 18, schedule 2, section 85: The section on reporting of health professionals seems to ensure a policy of open disclosure among professionals. We laud this section. An open policy about disclosure of sexual abuse supports client-patients in exposing the secret. Support for disclosure by professionals allows those professionals who find such behaviour abhorrent to come forward in safety about transgressions. Furthermore, it re-establishes the credibility of the profession in the view of the public.

## 1910

I'd like to just explicate that with a little example. I knew of a situation where an abused woman visited her local medical clinic, saw a doctor's services advertised in the office. It had his name and then it said, "Restricted to psychotherapy, specializing in abused women." She didn't understand the "restricted" part, that there might be a problem. When she asked this doctor to help her, he ended up attempting to seduce her. She was very frightened and it caused her to pull back. She was afraid of reaching out to anyone else for help. Upon inquiry, it was discovered this doctor had several complaints against him and had lost his licence to practise medicine, yet he was practising psychotherapy with the other doctors in the office knowing this.

What responsibility did the other doctors in the clinic have to protect the public, their patients? How was this man allowed to practise psychotherapy when he was found inappropriate to practise medicine?

I continue on. Subsection 85.3(6): This section, however, requires caution about the validity of any prediction about the potential for reabuse by the offender. The current ability to accurately and reliably predict reoffending behaviour is unreliable.

Peter Rutter, in *Sex in the Forbidden Zone*—and I might say this book is very much on topic with this; it discusses abuse of anyone in a position of power with the people under them, whether it be a minister with his parishioners, a teacher with students or a doctor with his patients and so forth—states: “Many men who sexually exploit professional relationships are so-called repeaters who count on the silence of their victims,” and it truly is very difficult for victims to come forward. Therefore, any predictions need to err on the side of protecting future victims and the public to maintain professional credibility. The fundamental injury to each and every victim’s quality of life caused by such abuse must be considered.

Finally, my colleagues ask me to convey to you the need to solicit further input from advocate groups.

**Mr Owens:** Let me begin by thanking you, Ms Emerson, for appearing this evening. I understand clearly the short period of time you had to prepare your presentation. It’s excellent none the less.

My concern is around the reinstatement of physicians or practitioners who have been found to have abused patients. In your role at Apple House you’ve had much more opportunity to deal with victims of sexual abuse, more than I will ever have. What is your view on the reinstatement of practitioners who are found to have abused?

**Ms Emerson:** I suppose it’s difficult to generalize. It would depend on the degree of pain to that client, but frequently with women who have been abused—they may have been abused previously—they are potential victims. If they’ve been sexually abused as children, they may be afraid to say no to a doctor. They may not be clear on what their rights are with a health practitioner. They are very afraid of the person in power and of standing up to them, and when they have been reabused, the trauma is very extensive and it takes years to recover, even with a sexual abuse survivor. For instance, if a child goes to her mother and the mother denies that the sexual abuse happened, that is a retrauma. If the child grows up and then is further sexually abused, it’s further trauma. The more it happens, the less likelihood they’re going to live a normal life and they’ll most likely be in therapy a good part of their life.

**Mrs O’Neill:** I’d like to ask you about the suggestion you have regarding the amendment to section 51. As I look at it myself, and of course I tend to agree with the previous speaker—you no doubt have much more first-hand experience than I—subparagraph viii, I guess it is, seems to include what you have suggested: sexually seductive or suggested behaviours. Could you tell me why you feel another section is needed?

**Ms Emerson:** Can you indicate which page that is on?

**Mrs O’Neill:** You mean of the act? It’s page 3 of the act as presented, under “Orders relating to sexual abuse.” As you know, there are at the present eight definitions or statements of what would be included in sexual abuse, and you’re suggesting there should be this ninth one added.

**Ms Emerson:** I guess that viii was not clear enough.

It sounds like a direct sexual action whereas our suggestion for ix would be anything that might lead to that; it might not be an action. I can think of a case myself where I had a doctor who was very unclear about his professional boundaries and in draping me was not professional. He didn’t touch me, but his look, the way he ordered me to keep my hands away while he did the draping—and he lifted my pants and was able to see down my pants while he was doing this—felt sexually seductive. I’m not saying that he should be revoked for that but he certainly deserves some disciplining. That’s not—

**Mrs O’Neill:** So even in your definition and even with an example, it’s pretty hard to define exactly what you mean. When you began, I thought you were going to talk about words as well.

**Ms Emerson:** Yes, it could be a verbal message that’s seductive too.

**Mrs O’Neill:** In your addition, do you see an ability for that ninth to be a very personal interpretation?

**Ms Emerson:** Yes, perhaps it would have to be clarified.

**Mrs O’Neill:** It might be helpful, if you feel there is something left out, to try and be somewhat more specific, because this is an act that’s going to affect the entire province, and your experience may have to be defined a little more closely.

**Ms Emerson:** If I could think about that, I’ll submit it to Mr Owens.

**Mrs O’Neill:** We would appreciate you presenting it to us if you think there’s something that has been left out of that list.

**The Vice-Chair:** Mr Wessinger has requested a clarification.

**Mr Wessinger:** I’d just like to clarify that section 51 has been amended to delete items vi, vii, and viii from that list, so it’s really only i to v that are still in the bill. It should also, I think, be pointed out that those are acts where there’s a mandatory revocation for a five-year period.

**Ms Emerson:** So do vi to viii result in anything?

**Mr Wessinger:** They have been deleted, and for the other aspects you’d have to look at the definition of “sexual abuse.” I forgot which section it is where it refers to the “sexual relations” definition. These are the specified acts that would result in a mandatory revocation. The other descriptions are sexual touching, which are not a mandatory revocation.

1920

**Mrs O’Neill:** I think the difficulty is that many of the presenters don’t have the amendments. The amendments haven’t been debated. The government has presented them and of course therefore presumes it’s happened, which I guess it may do, but the general public, in many cases, doesn’t see it that way. I think it is helpful if the presenters are made aware that there have been amendments presented, and if they want them, I think the clerk should give them to the presenters.

**The Vice-Chair:** That would be helpful. Thank you.



**Mr Drummond White (Durham Centre):** Thank you, Ms Emerson. Certainly, in the many years I worked as a social worker in Whitby with family counselling there I used Apple House on many occasions, and of course the Y and Higgins House before that.

I think you bring up a number of important issues. The behaviour within the context, for example, of dealing with someone who has been victimized is much graver than with someone who is not so vulnerable. I want to pick up on a couple of those points. Frankly, I quite agree with you that this is important—not the act alone; it's the context of the act, those physicians who are working with women who have been physically abused, and as we both know, many of those women have also been sexually molested or abused as well.

At the moment, in regard to your feelings about professionals who are working with women who have been victimized, the social workers, the counsellors like yourself, should we not also be accountable?

**Ms Emerson:** Yes.

**Mr White:** Should we not also be regulated to protect those very people?

**Ms Emerson:** I guess it depends on what you mean by "regulated." Yes, I believe that we are all accountable and I would hope that we would all be made to act in a professional manner. I have only a BA; I don't have an MSW or a PhD. But I conduct myself in a professional manner. My clients are not my friends; they expect me to be their counsellor, and that's what I give them.

**Mr White:** So you should be accountable in terms of your ethics?

**Ms Emerson:** Yes.

**Mr White:** Any health professional should be?

**Ms Emerson:** Yes. As a matter of fact, Mr White, in Durham region we have a wife abuse protocol that is being established. I believe many communities are establishing this. I am part of that. Victims are coming forward and have formed a group to make us accountable to them. They are saying, "We want agencies to be accountable to us." I think the government needs to be accountable to these victims too.

**Mr White:** Similarly, Ms Emerson, if you were to make a statement from your knowledge of a client who has been abused, you would want to have the same protection when you make that statement as any health professional. You would like to be able to be free of libel charges, as any health professional would be, right?

**Ms Emerson:** I suppose; it's not something I've worried a lot about.

**Mrs Dianne Cunningham (London North):** Thank you very much for your presentation. Just to follow up on what Ms O'Neill said, it's very difficult, as you know, for the public to give us good advice when they can't even get the amendments. But if you could, I would appreciate it if you would look at the definition of sexual abuse of a patient, because I think the proposed amendment might be something that you would support. I think it has described what you've stated, and I would be most interested in hearing back from you if you can call my

office. I think the clerk may have handed the proposed amendments to you tonight, did he?

**Ms Emerson:** Yes.

**Mrs Cunningham:** Okay. You would be most helpful in getting this to us quickly. As you know, the time frame is so short; we don't approve of it, but it happens to be what happened. It would be most important to get front-line persons such as yourself to give us your best advice.

**Ms Emerson:** Thank you. I will consult with other colleagues.

**Mrs Cunningham:** It would be great. I think it would be fair, Mr Chairman, if you could advise us. Is it Monday evening that we're doing our last public hearings, and Tuesday clause-by-clause?

**The Vice-Chair:** That's my understanding, yes. That's correct.

**Mrs Cunningham:** If you could get it to us before the weekend, it would be really great.

**Ms Emerson:** I'll see what I can do.

**Mrs Cunningham:** It's hard to get colleagues together on short notice. We would appreciate looking at it. You've been most helpful. I've enjoyed your presentation, as we have others this evening, but your clauses are very specific. Your wording is helpful.

**Mrs O'Neill:** Mr Chairman, because Ms Emerson said she has colleagues that she's communicating with, I think it's important for you to know that this bill is slated for debate for Thursday, December 9, for third reading, so that would be the date upon which the bill would be receiving the approval of the Legislature.

**Mrs Haslam:** I wanted to touch briefly on mandatory reporting. Do you believe that there should be mandatory reporting for behaviour and remarks—I'll give it to you in a two-phase area, so that you can answer quickly and others can go on—and should any professional under the RHPA be exempt?

**Ms Emerson:** I don't know what the RHPA is.

**Mrs Haslam:** I'm sorry, any professional covered under the Regulated Health Professions Act. Let's just say any professional: psychiatrists, psychologists, massage, dentists, doctors, psychotherapists. Should there be any exemptions? Do you feel that any of those professions should be exempted from it, and do you think there should be mandatory reporting of behaviour and remarks?

**Ms Emerson:** I cannot see an exemption. Of course, in massage, people would touch parts of our body, but there are definite ways they touch that are professional rather than sexual. I cannot see any exemptions in my knowledge, and I would think mandatory reporting is a great step forward.

**The Vice-Chair:** Thank you for your presentation.

IRENE CREWS

**The Vice-Chair:** The next presenter is Irene Crews. Is Irene present? How do you do. Have a chair. Would you introduce yourself and proceed with your presentation, please.

**Ms Irene Crews:** I am a member of Survivors of



Medical Abuse. Three and a half years ago, I was assaulted by a doctor. The doctor had lost a patient after he performed liposuction on her. He is still out there operating on women and putting money in his pocket.

In 1989, I went to see this doctor for a reason other than having cosmetic surgery. It was not an ordinary consultation. Part of what he did was to pull a stool up right close to me so he was straddling my knees, so my knees were about a quarter of an inch from his groin. He put his face right up near mine and talked on and on for about 20 or 30 minutes, telling me what an excellent surgeon he was and convincing me to have cosmetic surgery. The position caused a stressful situation for me, because if I moved even slightly, I would have touched him in his private parts. He talks with an accent, so I had to concentrate very hard to understand him, and at the same time, he made frequent contact by touching or patting my hand or arm. This happened on three occasions, and what I'm talking about is hypnotic induction. I wrote down this and submitted it to the college of physicians long before anything came out on the news about hypnosis and doctors.

That was in the spring. In the fall, it came out on the news about the liposuction death. That is when I went back and had the facelift. I believe he had left a suggestion in my mind, and when I read about him in the news, I followed up on it. The surgery itself was bizarre. It was extremely traumatic. The anaesthetic kept wearing off and I would have to ask for more. They would give me more and I would calm down, and then it would wear off again and I would become upset and agitated again. I was traumatized by it.

Part of the operation was a chin implant. When the first of the bandages came off, there was a big lump underneath my chin, which was the implant falling out, and it was infected. After the bandages came off, my friends told me there was no difference in my face from before the surgery. I have no dispute that he performed the surgery; I saw him there operating for three hours or so.

1930

The first time I confronted him, I had to hug him before I could leave his office. The next time I confronted him, I showed him pictures taken the day before surgery. He was again using the hypnotic technique, trying to convince me he had done an excellent job of surgery. I decided I did not have to sit there for yet another 20 or 30 minutes and listen to him. I got up to leave quite calmly, saying, "I am going home now and I will see you at your clinic on Monday." That is when he grabbed me. He put his arms around me and I was restrained from walking out of his office. I said things like, "I am going to scream," but he would not let go. At another time, he held my two arms together like this, and at another point, he stood in front of the door and barred it so I could not get out. It happened that I had a friend in the waiting room, because we were going to lunch after my appointment.

I filed a complaint with the College of Physicians and Surgeons. I did not have a hearing. They did not find sufficient evidence of assault. They did not address my

complaint of no difference in my face. They did admonish him for unprofessional behaviour, like, "Slap, slap, naughty doctor for being unprofessional with Mrs Crews." He is still out there operating on women and sticking money in his pocket, while I have had major depression and I have pain every day of my life which I did not have before.

There was a blatant lie in his letter of defence. In my written submission I described how his wife-secretary had come into the office only once, near the beginning of my appointment. I was in there for about an hour. He said I became upset, and he buzzed her and she came in and sat down and tried to calm me down and handed me a Kleenex. The assault happened near the end of my appointment. There were only two people in a small waiting room, my friend and his wife. He could not have buzzed her and she have left the waiting room without my friend seeing her, and my friend had already given her evidence.

My allegations about hypnosis were very serious, because it may be that the woman who died following the liposuction did not want the surgery either, and he may have used the same procedure to convince her. Why did the college not get his files and interview other patients? I cannot be the only person who had that experience.

My complaint also involves sexual violation, because of the intimate contact and having to hug him before I could leave his office.

I appealed the decision to the Health Disciplines Board, and after waiting a year to get a hearing, I contacted a community agency for help, the Toronto Rape Crisis Centre, who were able to get a hearing set up, and that was last week. At that time, I caught him up in several lies.

For starting a lawsuit, a lawyer requires a \$20,000 retainer. I do not have money like that. I lost my business since the assault and have had to use up savings. Even if I were eligible for legal aid, I would have a lien put on my house, and at my age I can't take a risk like that. Besides, chances of winning a malpractice suit are slim.

In addition to that, we saw a film in sociology class at George Brown College entitled Medical Aggression. A survey showed that in Sweden, where physicians are on salary, in 10,000 people, there were 17 hysterectomies performed. In Canada, where doctors are paid per operation, in the same number of people, there were way over 100 hysterectomies. It was the same with tonsils, gall bladder and other organs. If doctors are being paid per operation, there are many more performed.

Medicine is the leading profession in Canada, yet incompetence is high, and then the college of physicians covers up.

My recommendations, and these are for other than just Bill 100:

- (1) Put through Bill 100 in its entirety.
- (2) Take the responsibility for discipline away from the College of Physicians and Surgeons.
- (3) Change the legislation around lawsuits so lawyers can take the risk and take a percentage of the award for damages if there is one.

(4) Look at dismantling the OHIP system as it now stands. Let people still have free medical care, but put doctors on salary and put a ceiling on it at a reasonable amount. Then channel the money saved into hospitals so people will not have to be turned away. There is plenty of money around, but it is going into physicians' pockets rather than being used for the people.

**The Vice-Chair:** Thank you for your presentation. Are there any questions at this time?

**Ms Haeck:** I take it from your comment that you would like to see Bill 100 passed in its entirety, that you would agree, in whole heart, with the mandatory reporting aspect.

**Ms Crews:** Wholeheartedly.

**Ms Haeck:** Very good. I just wanted to make sure that there was no guesswork involved in here, because it's definitely something that, on behalf of the victims, I do support.

**Ms Crews:** Yes, thank you.

**The Vice-Chair:** Any other questions? Thank you for your presentation.

#### ONTARIO DENTAL HYGIENISTS' ASSOCIATION

**The Vice-Chair:** The next presentation is by the Ontario Dental Hygienists' Association. There's been a handout, I believe. We have a letter from the Ontario Dental Hygienists' Association addressed to the clerk of the social development committee:

"The Ontario Dental Hygienists' Association wants to thank the standing committee for making time available for us to present regarding Bill 100.

"Please have read into the record, in the time slot that would have been available to us, that the Ontario Dental Hygienists' Association has already submitted a written presentation which we trust will be duly considered by the standing committee. We are pleased that more time has been made available for discussion on Bill 100 even though we will not be attending in person.

"Again, thank you for contacting us.

"Sincerely,

"Elizabeth Craig, Executive Director."

#### ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS

**The Vice-Chair:** The next presentation will be by representatives of the Ontario Association of Medical Radiation Technologists. Good evening. Please be seated, introduce yourselves and proceed with the presentation.

**Ms Haeck:** On a point of order, Mr Chair: On one of our lists, we have a Catherine Eckler listed at 7:15.

**The Vice-Chair:** That's not on my list.

**Ms Haeck:** Maybe it was an older list, I don't know.

**Mrs Haslam:** It's the last one I have.

**Ms Haeck:** Thank you.

**The Vice-Chair:** Oh, is it cleared up?

**Ms Haeck:** Yes, we're fine now. She had an extra one.

**The Vice-Chair:** I see. Thank you. Please proceed.

**Mr Robin Hesler:** My name is Robin Hesler, execu-

tive director of the Ontario Association of Medical Radiation Technologists, a predominantly female profession. Prior to taking on this position, I was a practising medical radiation technologist in the discipline of radiological technology.

With me this evening is Roberta McCammond, our immediate past president and a practising radiation therapist.

The practice of our profession, like many others, involves the use of our major senses, particularly touch. As a result, our members are in an exposed climate and thus vulnerable. Bill 100, then, is of great interest to us.

We have been pleased to be a part of this historic process. The interaction with victims, survivors, sister associations, governing bodies and the government has given us an acute awareness on the issue of sexual abuse and broadened our respect and understanding on this matter. It indeed has been a truly educational experience, which I state in the most positive sense.

Mr Chairman, we thank you and the committee for this opportunity to appear before you this evening.

We have been a member of the Ad Hoc Coalition of Regulated Healthcare Associations on Bill 100 since its formation. We sit before you as a strong supportive voice to the views they have already so eloquently articulated to you regarding the issues around Bill 100. We are not here, however, to restate those arguments in general or in detail, except for two.

Before I address those matters, I would like to state that the association recognizes and supports the objectives underpinning Bill 100. We recognize that society as a whole and government in particular have an obligation to deal with the issue of sexual abuse with the connotations, perceptions and realities that this term may conjure up. It is because of this recognition and our awareness that we asked to meet with you tonight.

#### 1940

In our position paper to the government on Bill 100, we raised the issue that, although well intended, this legislation appears to be restrictive, discriminatory and a gateway to potential problems as time goes on. Bill 100, in our view, is restrictive in scope and discriminates against the health care professional, the survivor and the victim, and it could be a barrier to practice.

We have come to perceive that in its haste to act to stop sexual abuse because of the highly publicized incidents, the government of Ontario has unwittingly compromised its own principles of fairness and equity. This strong desire to stamp out the problem set into motion a patchwork process, a quick fix, if you will, by grafting more legislation on to the RHPA. This legislative minor surgery, however, does not and will not heal the gaping wound of sexual abuse in our great province. Major surgery is required through new legislation to begin to heal those wounds and to act as a preventive care tool.

Focusing only on health care professionals is seen to be, by our members, discriminatory, unfair and unreasonable. Sexual abuse is a problem in other sectors of our society. Most health care professionals act professionally.



We do not have to look far to see that sexual abuse prevention should not be just focused on health care professionals alone. If we shift our vision to the unregulated health care providers, there are many who share the characteristics of authority, power and trust.

As an example, our association has only to glance over to a related health care provider group, ultrasonographers, or sonographers, as they are often called. The practice of this medical occupation requires extensive risk management techniques and the use of hands-on techniques as well. The impact of the insertion of probes, called transducers, into various orifices of the body provides a sensitive environment for the patient and the sonographer. The nature of the work provides a potential for sexual abuse. This occupation is not subject to RHPA and therefore not subject to Bill 100. Is this fair? We think not.

Ultrasound is only one example, and we use it because some of our members practise both medical radiation technologies, a regulated practice, and ultrasound, the unregulated practice. These members are having difficulty understanding the logic of Bill 100 affecting them in one part of the day but not in another part of the day. We feel this makes the issue of mandatory reporting an interesting one. We are aware that this unregulated health care provider group is only one of many examples which the coalition has noted already.

Sexual abuse occurs throughout our society wherever power relationships and other causes manifest. Then why should health care professionals be unfairly singled out? Why are we being singled out as the bad ones? It is on this basis that we suggest standalone legislation to address sexual abuse within the province of Ontario.

We believe the government of Ontario has a wonderful, unprecedented opportunity of historic proportion to devise innovative model legislation concerning global sexual abuse and produce truly great legislation. We believe that Bill 100 has provided the base for such new legislation, as well as the reference to draft regulations under RHPA concerning the sexual abuse provisions of that legislation.

We believe that in addressing standalone legislation, it will provide the government with the opportunity to address the anomalies and problems that others before us have presented to you which otherwise might be difficult to accomplish in Bill 100. One of those areas is the therapy and counselling fund. We are a profession where incomes are modest and shrinking in today's fiscal realities. We are a profession whose demands on it are great and, due to cutbacks, are becoming even greater. We have already witnessed in radiation therapy the problems of the shortage of therapists. This was temporarily solved by hiring from out of country.

The compensation fund, the way it is being proposed, could be the straw that breaks the camel's back for our profession. With the spectre of this added to an already stressed health professional group, we could be facing a major shortfall as our members leave the profession and we cannot attract young citizens of this province to enter our undergraduate programs for fear of the barriers before them. We could be jeopardizing and undermining health

care in the long term. Do we want more stress, which then translates into possible sexual assault or abuse in the rest of our society? Could this well-meaning legislation be doing this? We believe the possibility for this is excellent.

What we need is comprehensive, all-encompassing legislation addressing sexual abuse on a macro-scale. What we need is a balanced approach which ensures the democratic principles of equity, justice and fairness, as well as accountability. What we wish to avoid is the potential to corrode the purpose and effectiveness of the RHPA. What we wish to see happen is the respect of the rights of all citizens of this great province.

If you tell us that standalone legislation is not possible and ask whether we could live with Bill 100, we would say yes, on the proviso that those recommendations that the Ad Hoc Coalition of Regulated Healthcare Associations on Bill 100 put before you are actioned. As it stands, it is a piece of legislation well intended but substantially flawed and poised for legal challenges and therefore potentially costly to our fragile economy and societal health.

Mr Chairman, this concludes our presentation. I'd like to thank you again for this opportunity to appear before you, and especially for your time.

**Ms Haeck:** Thank you. I appreciate your remarks. You have some strong convictions here, and I have to admit I have some as well on this particular issue on behalf of the victims and the survivors.

I am concerned about your comment on page 4 in particular, where you indicate that you perceive there's some sort of haste in this whole procedure.

I did have the privilege of sitting on the regulated health professions hearings which occurred during the summer and fall of 1991, and during that period Marilou McPhedran made her presentation of her report, in November 1991. We are now almost at December 1993. In our briefing package, which I'm sorry you don't have, there is a chronology of events as well as a range of things here.

My question is that through this whole process, knowing that this was part and parcel of the Regulated Health Professions Act—it was flagged at that time in November 1991, placeholders being put there for all of the professions—and there having been two years that have elapsed through this whole process, I am somewhat concerned about the word "haste." I'm just wondering what kind of consultation you have participated in over that period to bring forward your particular view.

**Mr Hesler:** To answer the last part of your question, we have been involved with the government in the opportunity to present the brief. We've been involved with all the coalition meetings that were mentioned in its brief. We've also been involved with the meetings that the professional relations branch set up with the victims and survivors. So we have attended all those meetings.

What we're alluding to there in terms of haste with this is that when the College of Physicians and Surgeons' report came out, things seemed to be set in motion very quickly as to exactly what was going to happen with Bill



100. It's our perception anyway that there is such a strong desire to get this legislation through within a particular time frame that perhaps it is not giving enough time for the seriousness of this legislation in order to really take a very good, close look at it.

We've always been under the perception that we have to meet a particular deadline, which is December 31, or there will be problems with the legislation. We've gotten things from the professional relations branch and the "respond to this now, respond to this now, respond to this now" has given us that perception.

1950

**Ms Haeck:** You mean that in two years' time you don't feel some of your concerns might have been allayed? There are a fair number of survivors of sexual abuse by medical practitioners sitting in the audience, and they are obviously very concerned that this would be prolonged even further. How do you address the very real concerns on behalf of the ladies who are sitting behind you?

**Mr Hesler:** All we're concerned about is that those concerns are addressed and that any attempt to speed the process up may in fact not do that process justice. That's all we were concerned about.

**Ms Haeck:** As someone who is a government member, the fact is that their concerns have been, to some degree at least—I get a sense from a number of the presentations I've heard over the last few days that they feel this should have happened some time ago and that we've taken a bit long in getting to this point.

**Mrs O'Neill:** Thank you for your presentation. I too feel somewhat rushed in this, in that the legislation is before us now. There's been a lot of consultation, but I always find in opposition that all this consultation goes on, but when the legislation comes there is quite a hurry, and that's not just with this bill.

I haven't had a lot of opportunity to be into this area of any hospital, but the ultrasonographers and the radiation technologists sometimes are very much side by side in the environments I've been in. I'm just wondering if either the parliamentary assistant or our legal people would be able to tell us just what the obligations would be when you have people side by side, day by day, and one's regulated and one's not. What kind of obligation is there vis-à-vis these individuals?

**Mr Wessenger:** This legislation only applies to regulated health professions and does not apply to the unregulated health professions. If one wanted to have some legislation applying to unregulated professions, I think there would be a great difficulty in trying to have an enforcement procedure at this stage.

**Mrs O'Neill:** Well, I must say this one would be an extreme contradiction in the mind of a patient, because these people literally are shoulder to shoulder in the two or three environments that I know, and to feel that one would not be able to transfer some kind of obligation between these two individuals or to establish the credibility of one and not the other is very, very difficult for the average person on the street to understand.

**Mr Wessenger:** I think it should be understood that

there are other courses. For instance, a situation of abuse could be reported to a hospital administrator with respect to one of the unregulated professions.

**The Vice-Chair:** Did you wish to respond?

**Mr Hesler:** I just wanted to add a clarification to that. Often we're finding too it is the same person. The person will be doing X-rays part of the day, and then the person is doing ultrasound another part of the day. With the changes in the health care system going on, that likelihood to utilize people more is more than likely going to increase.

**Ms Haslam:** I was going to follow up on the idea of standalone legislation. I can see your concern about connecting this bill to the RHPA. I'm sure you'll note, however, that this bill does rely on the disciplinary mechanisms within the RHPA. Does your recommendation for standalone legislation mean that such legislation would simply repeat what's in the RHPA, or are you suggesting that we start all over again with a new and different approach to the problem of sexual abuse by the regulated health care professionals? My concern obviously would be delay in the legislation.

**Mr Hesler:** Yes, and that's our concern too. As far as the RHPA is concerned, I think it is very important that the accountability and responsibility are placed there. How that's done, through regulations or something, using Bill 100 as the base, I think would be very important to do.

We honestly think it's very, very important to look at the whole global picture here and maybe step back and say, "Yes, there is a requirement out there for the unregulated professions and professionals as whole within society, and how do you do that and how do you make them accountable?" I don't know.

**Mrs Haslam:** Could we then say this is a good first step—

**Mr Hesler:** Yes.

**Mrs Haslam:** —and there obviously is an area where unregulated health professionals have to have some sort of code of conduct also, but as a first step this legislation is where you want to be, tied to RHPA?

**Mr Hesler:** Yes, we would accept that as a good first step.

**Mrs Haslam:** Thank you.

**The Vice-Chair:** Thank you. Mrs Cunningham.

**Mrs Cunningham:** That's fine. I was seeking further clarification, as Mrs Haslam was, so that's fine.

I share your concern with regard to timing. I am wondering if you have had a chance to take a look at the definition of "sexual abuse of patient," the new proposed definition which takes into consideration—actually it's clause (c)—where we are looking actually at the "behaviour or remarks of a sexual nature." I think that will probably meet the concerns of many of the witnesses who have come this evening. Have you had a chance to look at that?

**Mr Hesler:** No.

**Mrs Cunningham:** Again, I think this is a group of people who work in a medical environment who could

probably assist us in that regard.

I share your concerns about this not being more global. I know some of you work in intensive care units and what not, where these kinds of things are happening. As you've described, part of your day is as one profession and the other is another and it's pretty hard to switch gears. But I would like to hear your opinion on the new wording if you get a chance to look at.

**Mr Hesler:** Okay. Thank you.

**The Vice-Chair:** We'll do that for your suggestion and we'll have the clerk do that. Mrs Haslam, did you have another point?

**Mrs Haslam:** I wondered if I could get some clarification. The comment was that there was a worry about the compensation fund. It was my understanding that the compensation fund was prorated and it looked at the number of cases over two years. If there were no cases, then the input from a profession was a mere \$10,000. Am I correct in that?

**Mr Wessinger:** I think the clarification is that if there are no previous cases the requirement is that there be \$10,000.

**Mrs Haslam:** As a minimum.

**Mr Wessinger:** Yes, as a minimum.

**Mrs Haslam:** Right, okay. Because there was some concern in this brief about the compensation fund. I wanted to be very clear on that.

**The Vice-Chair:** Thank you for your presentation.

**Mr Hesler:** Thank you very much.

#### NATIONAL ASSOCIATION OF WOMEN AND THE LAW

**The Vice-Chair:** The next presentation is by a representative of the National Association of Women and the Law. Would you introduce yourself, please, and proceed with your presentation after you're seated.

**Ms Nicole Tellier:** Good evening. My name is Nicole Tellier. I'm delighted to be here. I'm delighted that a government has decided to take some positive and fairly strong steps to deal with what is clearly a very pervasive problem in our society.

I'm a little disappointed in the lack of time to present, so I will either not get to all of the recommendations that are before you in a brief, or talk quickly, or both.

The National Association of Women and the Law is a national non-profit organization. We've done a lot of work in this area and appear frequently before committees such as this and in Ottawa.

I am a practising lawyer and have a large practice involving civil litigation and sexual harassment cases where my clients are victims of sexual assault, so hopefully I can bring to bear on the recommendations of my organization some personal perspective and experience.

At the outset I'd like to say that I think the committee, and I do think it's represented in the bill, must be extremely mindful of the fact that sexual assault is a gendered problem, that it occurs when people are in positions of power. Virtually every task force or commission or study that has been done repeatedly reveals that men are perpetrating assaults upon women, by and large.

I think that basic principle should inform the legislation, and so we have actually set out some proposals which suggest this bill doesn't go far enough, that some of the important ingredients that were in the original task force report do not find themselves in the bill. I will highlight them for you.

#### 2000

We have 12 recommendations which are summarized in the first two pages of the brief. I think that they could probably be summarized from a thematic perspective in this way:

First, we would like to see the bill strengthened through a preamble that does acknowledge the power and gender construction of sexual assault.

We'd like to see an increased participation of victims in the disciplinary process, both in terms of procedure and substantively.

We would like to see an expanded definition of the kind of abusive conduct that would be captured by the legislation and an expanded definition of those who are potentially named as victims.

We would like to see improvements to the compensatory scheme that is proposed in the bill.

Finally we are ad idem with the bill as it now exists and the suggestions by the task force that there should be no watering down whatsoever with respect to the principle of mandatory reporting. This is critical if professions, whether they be health professions, lawyers or others, continue to enjoy the privilege of self-regulation. We have lots of recent examples, the most recent perhaps in the judiciary, my profession, which show us this is absolutely necessary.

We think that a preamble is important because, as lawyers, a preamble can be used to breathe life and strength in other parts of a piece of legislation if there is any doubt as to what it means. We want to see the preamble used in that way as an interpretative tool, which is how preambles are used. But we'd also like to see it used to build on the notion that sexual assault stems from the context I described earlier, one where there's an imbalance of power and one where the interests of men and women are diverse and there is a gender issue.

We think that a preamble would achieve those goals and have set out in draft legislation a possible preamble. In each one of our recommendations we have actually provided you with draft legislation and we hope that will be useful and you'll actually give it careful consideration.

The second recommendation relates to the definition of "sexual abuse." As is typical, there seems to be, when defining this problem, a preoccupation with sexual intercourse. It actually appears as the first descriptive word of sexual abuse. In doing so, it conjures up a very narrow construction of what sexual abuse is all about. We prefer the concept of sexual penetration, which would capture not only body parts being inserted in different orifices, but things such as objects. This is consistent with proposals we have made to amend the Criminal Code.

We also recommend that the reference to sexual relations be deleted. It connotes mutuality in that there is an ongoing sexual relationship, when in fact there is non-



consensual physical contact. We think the choice of these words is pretty critical.

Finally, we are glad to see that behaviour or remarks are included, and we have suggested a slight change to clause 3(3)(c), which would refer to sexual harassment. Again, I won't go into it. It will refer you to the text. I think it's critical that mandatory reporting be preserved for this subsection. In my view and in the view of our organization, any sexual commentary or behaviour or remarks are completely unacceptable in the context of a professional relationship. What may be considered humour by some is offensive to others. We must make sure that we don't trivialize those kinds of situations which create a completely untherapeutic and hostile environment.

We would like to ensure that when determining what is of a sexual nature, the perspective is victim-driven and in particular gender-specific. We have seen from many difficulties in the Criminal Code and other situations that what seems reasonable to a man is not reasonable to a woman. This has been recognized by the Supreme Court of Canada in a number of cases. Lavallee comes to mind and others that are referred to in the brief.

Hence, we are recommending that the legislation adopt a legal perspective and standard which has a subjective and objective component, that it is gender-specific and victim-driven and that it is a reasonable man or reasonable woman test.

We'd also like to see an expansion in the definition of "patient." It's our view that sometimes therapy can be terminated precisely to engage in a sexual relationship or that shortly after therapy has been terminated there is still a vulnerability that must be addressed and protected. Therefore, we would like to see the definition of "patient" expanded to include "former patient." Again, there is a language provided to you for your assistance.

An important component to our recommendations, as I said earlier, was a more meaningful participation in the disciplinary procedure on behalf of victims. We would like to see a mandatory right to full party standing in all cases. In our view, every victim or survivor of sexual abuse at the hands of a health care professional has a genuine interest that frequently parts company with the public interest or the interest of the particular college, and you will get better results in law if all interests have an opportunity to be voiced and considered and addressed.

If such standing is to have any meaning whatsoever, it is critical that funding be made available. I realize it's beyond the mandate of this committee to consider reforms to the Ontario Legal Aid Act. At present, there is discretion to provide counsel fees for some disciplinary hearings.

I would like to see, and it's NAWL's recommendation, that the burden be borne by the colleges. I'm sure this will be considered to be contentious. It's contentious enough that we are asking the colleges to bear the burden of compensation. However, it's our view that it makes most sense to distribute the costs of legal representation among the health care professionals who wish to continue to enjoy the privilege of self-regulation, rather than the individual.

We are already spending millions of dollars through other benefits available to survivors, because we are dealing with a Band-Aid solution rather than upfront problems. We see legal representation acting as a way to improve the process and to bolster both the specific and general deterrent effect that this legislation clearly hopes to have.

We suggest that the college itself provide not only payment for counsel but that survivors have counsel of their choice. All too frequently victims in the disciplinary process are assigned counsel who are insensitive, who do not represent their interests and act in the public interest, which can sometimes unfortunately be at direct odds with the victim.

I believe I've made sufficient commentary on mandatory reporting. It should not be diluted or amended in any way, in our view. It is one of the cornerstones of this piece of legislation.

In terms of the actual compensatory scheme, we would like to suggest that some of the principles and procedures that are currently available under the Compensation for Victims of Crime Act be a model for this compensation. First of all, the kinds of things that compensation can be provided for should be expanded and not restricted to therapy. It should be clear that compensation for therapy that is incurred up to the time of the hearing is covered. We recommend that you look at considering a discretionary application for interim compensation, which is currently unavailable under that compensatory scheme here in Ontario, and finally, that the costs of therapy not be restricted to certain kinds of therapists. I'm not suggesting there be no minimum qualifications, but we wish to avoid a situation where counsel is dictated, the therapist is dictated and basically the victim once again does not have control over what is critical: (a) her representation and (b) her healing.

We have suggested a creative way which might assist in the burdens that would be created to various bodies by virtue of requiring them to fund the compensation scheme, and that is to amend Bill 100 such that sexual abuse could constitute not only professional misconduct but incompetence under section 52 of the act.

We would like to see this as a matter of principle, we would like to see it because it means there would be an incapacity to continue to practise immediately pending appeal and therefore it provides more protection and, finally, if we use this characterization of the misconduct, it seems quite possible that the insurer may be able to cover the compensation.

Since I'm sure you all have questions and I've rushed through this in what I hope is within my allotted time, I'll end there and open the floor to whatever questions you may have.

2010

**The Vice-Chair:** Thank you. We have time for one question because of the shortage of time.

**Ms Haack:** Thank you very much for a thought-provoking presentation. As you probably can imagine, and you have alluded to it, there is considerable debate about whether or not the colleges should really be bearing



the brunt of the funding, as in your point 10. There has been a suggestion in fact that it should be government-funded. What would your reaction be to that?

**Ms Tellier:** I think as a basic principle, the compensatory scheme should be spread among society rather than borne by the individual, which is the current problem. I do think, however, that to achieve a deterrent effect, it might be more meaningful at the moment to have those who are committing the assaults be directly responsible to themselves.

I think it's consistent with the requirement of mandatory reporting that if a body is to be self-governing, each member of that body should be contributing to the welfare of those to whom it delivers professional health services and should be vigilant about its coworkers. We have not given that a great deal of thought. I wouldn't exclude that as a possibility entirely.

I would like to see some, for lack of a better word, punitive component, if there are particular health professionals, and I suspect this is borne out by the statistics and I suspect we all know who they are. If they are doctors and they are in the position to pay the most, then they should do so.

**Ms Haeck:** Thank you. I'll allow someone else to ask some questions.

**The Vice-Chair:** Thank you. Ms Cunningham.

**Ms Cunningham:** I've really enjoyed the presentation, but I'm very frustrated because it's going to take me some time now to cross-reference this with the most up-to-date recommendations for change. I'm wondering if you have even seen them, the last group of government amendments. Is this brief referring to the more recent government amendments or the original bill?

**Ms Tellier:** It's referring to the original bill that had its first reading on November 25, but we were aware of some proposals. So I was aware of the amendments to the definitions section, and we go further than that.

**Ms Cunningham:** Okay.

**Ms Tellier:** I hope I haven't confused you with the numbering.

**Ms Cunningham:** No.

**Ms Tellier:** There is also a suggestion or proposal on the table, I think, to minimize the powers of counsel, which is not in the original bill, and I've actually addressed that as well.

**Ms Cunningham:** Yes, I saw that. We'll give it some time, but I guess my question now would be to the parliamentary assistant. My great concern from the very beginning, from a couple of weeks ago when I realized this was going to happen, and with the same kind of pressure as everyone else wanting some action to be taken, is that I'm wondering how many times we're going to have to look at this again and make some of the changes you've recommended that aren't here now, either by recommendation of the committee for regulations or process or something, some of the things that you've given us some ideas about.

I suppose my question ought to be, to the parliamentary assistant, what is going to happen with some of these

far-reaching recommendations? If we've got 15 minutes for every presenter, when do we have an opportunity? Surely not in committee of the whole. Clause-by-clause, I think, is scheduled for one afternoon and evening. Is that correct?

**The Vice-Chair:** That's my understanding.

**Ms Cunningham:** If we take the time to do the work, which some of us are prepared to do if we think someone's going to be seriously listening, is the government going to be taking a look at some of the recommendations that we've had this evening and coming back to us with more proposed changes? Would that be the best way to do it? Or do you want us to do the work as well? Often I find that if we do the work, we don't have any recognition for it; the government's made up its mind ahead of time.

In this instance I think there's probably been some work with the government done. I'm not sure I'm correct in that regard, but my feeling is there's an amount of expertise here that we should be tapping. Could I have Mr Wessenger tell us what he thinks the process will be?

**Mr Wessenger:** First of all, I think there should be some clarification with respect to the amendments that have been submitted. I understand that these amendments had all been gone over with the stakeholders back in August, so there was consultation.

**Ms Christine Henderson:** And October.

**Mr Wessenger:** August and again in October. So in fact there has been consultation with respect to the proposed amendments.

I think it's also been made clear in the statements that have been made about one future amendment that is going to be submitted for consideration by the government, the one additional one—I don't know of any others at this time, but one additional one relating to the category of sexual abuse of a behavioural or verbal manner—that there's going to be a provision for the colleges to look at some form of assessment and remediation.

**Ms Tellier:** Could I just comment on that? I think process is very important, as someone whose consultation is sought. I did have the opportunity to consult with the Ministry of Health and was grateful for that, and I was provided with these amendments. But I think the question that's in part being raised by the honourable member Cunningham is that we who come here to present have no sense whether our recommendations, which you have not seen before—we've seen your position—are really going to be given any meaningful consideration.

**Ms Cunningham:** That's the point. I'm not trying to be controversial, but I could spend a lot of time with four or five of the presenters tonight and come forward with the amendments, which will take a lot of hours, which I've done before, and I'm feeling fairly frustrated because they haven't been given any significant thought; I mean, it's over and done with. So that's why I'm asking the question.

It's not the first time we've heard about the need for a preamble, for instance. We heard earlier from the executive director of Metrac, who referred to your brief later this evening, which we were looking forward to

because she said you would be expanding on that need. Is the government considering that? That would be a fair question, because if you are, we can do some work on it together. I'm prepared to do the work. I would prefer to do this work in the break, because I see this as a major amendment that could be brought forth when the House resumes and we could really get a lot done. There just hasn't been the opportunity in the last two years to get it done to the extent of the kinds of suggestions we've heard this evening, a lot of which you said is not new to you but it's new to me. If we have to have it done by next Monday evening, which is the time frame you've given us, is there serious consideration being given to a preamble, for instance, by the government?

**Mr Wessinger:** I think it's very premature at this time to make an assessment of what other amendments the government may consider. Let's just say that we are listening to all the presenters, and based on what we hear from all the presenters, there may be some amendments. This whole question of sexual abuse has been going on for a long time. This legislation is an attempt to achieve a balance between the survivors and the health professions, a workable balance, one that will work for the future.

2020

**Mrs Cunningham:** Could I ask another question then? Some of the presenters this evening have informed us that they've been able to respond to the government and others have said they haven't seen the amendments at all. In one case there was a representative from Durham, I believe, from Mr White's constituency, who hadn't seen the amendments at all, and yet they've worked together as professionals. That's my understanding. I'm sure that there will be some follow-through because they're going to now respond to the amendments, that kind of thing.

**Mr White:** On a point of privilege, Mr Chairman: I'm no longer employed in the region of Durham; I'm employed by the provincial government. I did formerly work with that person, but that was long before this bill was suggested.

**The Vice-Chair:** Thank you for that clarification, Mr White.

**Mrs Cunningham:** I'm sorry I even mentioned it. I've been a social worker in London for five years. I have to say I could never do this job if I didn't tap into the front-line workers that I've dealt with over the years. They're the most significant contributors to anything I can do because I can pick up the phone and they tell me how things are now. I feel like I've been away so long.

**The Vice-Chair:** Please proceed, Mrs Cunningham.

**Mrs Cunningham:** Well, I will. I'm just wondering then if I could ask a question perhaps of the parliamentary assistant in this regard. If we do come up with a lot of new amendments that reflect and we find that we're not going to be able to get through them on Tuesday next week, is there any thought from the government that we can postpone this piece?

**The Vice-Chair:** There is a correction as well. The deadline for the amendments is 5 o'clock on Tuesday. It

does not include the evening, I'm informed. It's the afternoon of Tuesday.

**Mrs Cunningham:** So we have an hour and a half to look at amendments.

**The Vice-Chair:** I believe so.

**Ms Tellier:** One easy solution that has often been done in criminal legislation is to build in a very easy amendment which is a review in a year to see how it's working. You might want to consider that one.

**Mrs O'Neill:** Very good.

**Interjection:** Yes, we do have advisory councils.

**Ms Tellier:** Thank you very much for your time, committee members.

**The Vice-Chair:** Thank you for your presentation.

#### ONTARIO ASSOCIATION OF PROFESSIONAL SOCIAL WORKERS

**The Vice-Chair:** The next presentation will be by the Ontario Association of Professional Social Workers. Are the representatives present at this time? Please come forward and introduce yourselves, and then proceed with your presentation.

**Ms Barbara Chisholm:** Good evening, ladies and gentlemen. My name is Barbara Chisholm. I am the spokesman for OAPSW this evening. To my right is Mr Daniel Andraea, who is the president of the Ontario Association of Professional Social Workers and can reply to any questions about the function, the operation, the structure, the wishes, dreams and policies and all the other things about OAPSW.

I appreciate the opportunity to meet with you this evening, and I appreciate as well the hour and the fatigue and the limitations presented by the restriction on time which looms within the world of reality. Therefore, I will restrict my comments to two areas only, leading to some suggestions we might make to committee.

We have had an opportunity to see the suggested amendments. We want to go on record as saying that we endorse the efforts of this proposed legislation. As professional social workers we are close daily, and one of the reasons, I suspect, that I have been asked to be spokesman this evening is that I am daily in my own practice close to the issues that it addresses.

I'm sure that you have heard a great deal around the two issues that we would like to speak to tonight: the definition issue and the mandatory reporting issue. Forgive me if we are repetitive of other groups that have already commented ahead of time.

We believe that the definition as suggested which contains the phrase "sexual abuse" is too broad as presently structured. In its attempt to be effective, it casts, as structured, too wide a net and therefore runs the risk of focusing on, if you will, the small-fish dilemmas that will arise and perhaps run the risk of losing some of the more significant issues.

This point of view comes out of the experience we've had in both family violence issues and child sexual abuse issues, in which the issues of mandatory reporting have created a backlog problem now that is very serious in terms of the quality of investigative skill that's available



to deal with reports as quickly as the protocols require. In my own experience, I know that, realistically speaking, sometimes serious situations have had to literally wait because of the preoccupation with a minor one. That becomes a judgement call, and I acknowledge that, but nevertheless we are concerned about that.

In the last analysis, even with definitions the decision to report or not to report is a judgement call. The goal of reporting must be seen to be the possibility of action response. There is no point in having excellent legislation mandating reporting if there is not a structure in place that allows you to do something constructively, responsibly, professionally with that report. The issue in legislation surely must be that the public will see that something has happened because of the legislation, because of the reporting.

Therefore, it is critical that we avoid the possibility of overload, with its negative consequences, if this can be done in advance, just as with the Criminal Code there is a graduation, a range, from zero to 10 of severity of issues involved, the severity of the offence.

Therefore, we would support the suggestion, the recommendation of the coalition that the language be changed from talking about sexual abuse to that of sexual offence, that the theme within that be the exploitation of a relationship with a patient or the exploitation of a vulnerable patient by the accused member and that those offences be broken down to three groupings: sexual impropriety, which would include behaviour or remarks of a sexual nature by the member to the patient; sexual transgression, which would be touching of a sexual nature of a patient by the accused member; and sexual violation, which would include sexual intercourse or other forms of physical sexual relations between a patient and the member.

We would also suggest that in the definition of the techniques used in that latter definition of sexual violation, the legislation or the regulations include use of not just the member's body or any body parts but in fact as well instruments or implements since, in our social work experience, sexual violations occur with the use of a number of materials, not necessarily just with the body or body parts of the transgressor. In order to make sure that is not avoided, we would suggest you include that.

We would suggest that level 1, sexual impropriety, place upon the public and all professionals a duty to intervene—that if, for example, there is a practice of constantly telling inappropriate so-called jokes, that be finally spoken to—but that it be recognized, and I'll speak to this in just a moment, that voluntary intervention may lead to an obligation to report.

#### 2030

The obligation, the duty, to report we believe should sit on the second and third, the transgressions and the violations.

In the suggested penalties that are proposed in the legislation, there is a long list, which may indeed be deleted, I understand, of the various forms of sexual violation or transgression behaviour which would come under the rubric of touching.

In point of fact, if there is a decision to retain that long list, we would suggest a phrase be added which would say, "or encouraged and sought" after the word "prescribed" in the last two sections on page 3 of the proposed legislation, leading to a revocation of licence, so that again the word "prescribed," if that is used, does not provide a defensive escape hatch that says, "I've never prescribed any of this; it was all in his or her imagination. I as a physician did not write it. Show me the piece of paper where I prescribed it," as though it were a medication. "Encouraged or sought" this behaviour of touching would, in our opinion, block the use of that as an escape hatch.

However, it is our preference that this long list be deleted altogether, because in a sense it retries the issue. If the accused practitioner has indeed been found guilty of professional misconduct, that should be sufficient within the terms of whether it is (a), (b) or (c), 1, 2 or 3, impropriety, transgression or violation, to have assigned penalty, not to re-examine the details of the offence.

For a level 1 offence, that is, the impropriety, the person who insists upon telling bad jokes, who insists upon being salacious, who insists upon standing too closely to another person, all of the suggestive behaviour which is unacceptable and offensive and for a vulnerable patient may be frightening and therefore harmful, we would suggest initially that there be a reprimand and a warning for a first offence.

However, we would also recommend that you consider adding a second section to level 1 or introducing a subset to level 2 which would indicate that repeated offences of this nature and repeated reports of this nature would bring about penalty, not just reprimand but indeed penalty, so that what one is responding to is the range of offences, from so-called minor offences to the very serious ones.

In recognition of time, I will withdraw at this point and conclude my remarks.

**Mr White:** I'm wondering, in regard to the issues around reporting, Ms Chisholm, if I understand it correctly, social work is not one of the regulated health professions, although it's by far the largest mental health profession in the province?

**Ms Chisholm:** That is correct.

**Mr White:** Does the fact that it's not one of the regulated health professions place the clients of your profession in jeopardy?

**Ms Chisholm:** Thank you for raising that, sir. There is no doubt in our minds, as a professional organization and as professional social workers, that indeed this is so. I think it is fair to suggest that we are the most frequently-called-upon professional group to deal with all issues involving sexual misbehaviour, whether for babies, children, adolescents, youth, adults or indeed the elderly. We are expected, in terms of the mandated work of the children's aid societies, to respond immediately, effectively and with the notion of respect for the protection of vulnerable populations, particularly minor children.

We are often, and in my own practice, if I may speak as myself at this point, used as expert witnesses in issues where this very serious allegation remains unproven but



is influencing such issues as the custody of children in a separation or divorce struggle between former spouses.

There isn't any doubt in our minds that, as it presently stands, all of the clients of all of the social workers throughout all of this province will not have any protection from this legislation. I don't want to come here to talk about only that issue; therefore, I did not raise it as a primary issue. I wanted to speak to the legislation, Mr White, but I appreciate your providing the opportunity for us to say that we are very, very concerned. We want to be a part of this. We want to participate. We want to cooperate. We want to help. We think we have more than a little to offer and regret that we are not, at this point, a regulated profession.

**Mr White:** Secondly, in terms of the reporting, I understand that members of the regulated health professions are obligated to report where they are aware of their clients having been sexually molested. Now, as social workers will be working with the largest number of people who have been in that position, women who have been molested or physically assaulted, as we heard earlier this evening, they are not, under this legislation, required to report, as you are required to report, say, child sex abuse or child physical abuse.

**Ms Chisholm:** Child abuse issues, yes.

**Mr White:** But there is no obligation under this legislation for your profession to report any instances of sexual abuse by professionals. Would that not also give an added limitation to the effectiveness of this legislation?

**Ms Chisholm:** Yes indeed, sir. The paradox in which we find ourselves as a profession is that we have an ethical and moral obligation as set out by our standards of practice and the ethics of our practice and the guidelines to practise endorsed nationally and internationally. We have that mandate and indeed that obligation. Failure will subject us, those of us who are members of our college, to sanction by our college. But we are not in a position, ironically, to operate within the mandate of this proposed legislation. We regret that.

**Mrs O'Neill:** As usual, I find your presentation very helpful. I think that when you do come before us again, and I know you will, to request regulation, you should bring this brief because otherwise we're going to continue the contradiction that exists in this and many other situations.

I found it very interesting that you would talk about the mandatory reporting in the way you did, because there seems to be a great sense of security if we get mandatory reporting. But you want it to go one step further: What happens to the report? I'd like you to say a little bit more about that from both the perspective of your professionalism and the perspective of the people you work with, because I really do think that the credibility of this bill is going to revolve around that issue.

**Ms Chisholm:** It is not enough to have in place legislation that indicates good intent to protect the public from professionals in the health field. That is a first step. But if we require, if the legislation requires, if this Parliament, this House requires the obligation and places

more than a moral obligation on health professionals to intervene and/or to report when they have reason to believe, in the course and the context of their professional activity, that these violations have occurred, it is incumbent in terms of the public relations and public policy aspect of this intent and this legislation that there be mechanisms in place to deal with it.

There is a public out there which is becoming increasingly educated and sophisticated and litigious. As it becomes more litigious, it educates itself through the legal profession and the advice it receives from the legal profession. If we, as responsible professionals, report to the appropriate body and the appearance is that nothing happens, the seriousness of the fallout from that is not to be measured. The collapsing credibility, the weakness in trust, the whole approach that this was whitewashing intended to cover something but not do something becomes extremely difficult to address later on.

**2040**

There is, unfortunately, bad humour out there about the professional bodies' capacities to protect each other. We all are familiar with the bad jokes; we don't need to repeat them here. We all know them and we all go ha-ha when we hear them. But in my private practice, something approaching 96%, 97%, 98% of my referrals all come from the legal system. I spend a lot of my time defusing the anger and the rage and the frustration that many clients have felt about that system, both at the lawyer and at the bench level.

Please, don't pass legislation without implementing regulations and a budget, designated responsibility for implementation and mechanisms that can be shared with the public at large through written documentation and handbooks available in every physician's office, every psychologist's office, every social worker's office.

**Mrs O'Neill:** I really do hope your advice is taken.

**Ms Haack:** I am interested in your comments regarding the duty to intervene. We've had a presentation by—let me make sure I get the name of the organization correct—the Ad Hoc Coalition of Regulated Healthcare Associations on Bill 100.

**Ms Chisholm:** I'm sorry, the Ad Hoc—

**Ms Haack:** I'll show you the copy. In that, they talk about the various levels of sexual abuse and sexual impropriety, namely, "Behaviour or remarks of a sexual nature by the member towards the patient that causes harm to that patient...has the duty, acting reasonably in good faith and in the best interests of the patient, to intervene forthwith."

There are four processes which can be used by a member of one of the respective colleges to flag the sexual abuse of another. One of them is just "meeting with the member to admonish that member to cease such behaviour, to apologize to the patient, to seek counselling or to take such other remedial action as the member may consider warranted under circumstances." It goes on.

You refer to that in your own comments, is that correct?

**Ms Chisholm:** That's correct.

**Ms Haack:** I have a concern about that. In essence,

what it seems to overlook is the fact that at some point you have to establish the baseline, and that if you preclude mandatory reporting, there is no baseline. If you have to establish some kind of trend—and I think that's what we do have to do to track the abuse, however minor in some people's eyes, but obviously on the part of the patient it is real, it is demeaning, and should therefore be recognized—we have to report; we just have to get that in there.

Would you recognize that if a member hears of abuse and the patient who has advised that member of the abuse on the part of another member does not want her name used, as the legislation allows, that member should still go forward and report that particular action because it will establish a baseline and possibly, over time, allow the college to track the behaviour of that particular member?

**Ms Chisholm:** I think you're raising a crucial point. What I was suggesting was an attempt to find middle ground between what they have suggested—I share the concern that we not set everything over here and ignore over there. The point I tried to refer to earlier—I would have elaborated much more carefully if we'd had enough time—does not allow for the experience we all know, which indicates that certain behaviour, unchecked, increments in intensity. We know that from family violence studies and we know it from the experience of child sexual abuse, that it increments in intensity over time. So you're absolutely correct on that issue.

That was why I was attempting to suggest a middle-ground position, which is that it is probably impossible, and I'm not sure it's wise, for us to attempt to check at a mandatory reporting level every unacceptable bit of behaviour. That troubles me in terms of the broad range, for example, of a multicultural society where there are cultural norms of what's tolerable, for example, by men in one culture which I would find offensive in my culture. But I work with some of these people and have to find middle ground with them, because what they consider acceptable is not necessarily my definition, and it doesn't mean that their behaviour is reportable in my definition; unacceptable, but not necessarily reportable.

That's why I suggested this idea, which we would be prepared to elaborate in more depth and send a subsequent letter to you in more detail, that repeated—and we might try to struggle with how many repeats is good or bad—instances of this kind of unacceptable but less crucial behaviour which is offensive and possibly frightening and harming to a vulnerable patient—you're absolutely correct about that—falls within what becomes the orbit of mandatory reporting.

But to save that system which needs to be set up from having to treat equally at a response level somebody who hasn't got good judgement and has bad taste about his joke level and isn't very sensitive to what he's done to his patient's comfort level—equating that with the man who exploits that vulnerability to set a patient up to accept and endure his sexual advances and transgressions, we would be prepared to struggle to elaborate that if that would be of assistance to you.

**Ms Haek:** One suggestion I have made to another

presenter was that what becomes clear in all of these discussions, to my mind anyway, is that, as we've discussed it for the bench, I think some cultural sensitivity might not be averse for the broader range of the medical professions as well.

**Ms Chisholm:** That's right. We're aware of the damage that insensitivity can do.

**Ms Haek:** Right. I think I'll end there because I know we have a long list of presenters yet.

**The Vice-Chair:** Thank you for your presentation.

**Ms Chisholm:** Thank you very much. We appreciate your listening to us. Would you like us to follow up with a subsequent letter of suggestions and elaborating our position? Would that be of assistance?

**The Vice-Chair:** Yes.

**Ms Chisholm:** We'll be happy to do that.

**The Vice-Chair:** Do that through the clerk, please.

2050

#### WOMEN'S HEALTH IN WOMEN'S HANDS

**The Vice-Chair:** The next presentation is by Women's Health in Women's Hands. Good evening. Please have a seat, introduce yourself, and proceed with your presentation.

**Ms Vuyisuva Keyi:** Good evening. My name is Vuyisuva Keyi. I'm the health promotion coordinator at Women's Health in Women's Hands. Simone Hammond was going to come with me and do part of the presentation, but she's doing a workshop tonight so she couldn't come.

I would like to start this presentation by reading a poem for you that was written by a Somali woman. Her name is Dahabo Elmi Muse, and it's a poem on female genital mutilation.

Pharaoh, who was cursed by God  
Who did not hear the preaching of Moses  
Who was led astray from the good word of Torah  
Hell was his reward!  
Drowning was his fate!  
The style of their mutilation—butchering, bleeding,  
veins dripping with blood!  
Cutting, sewing and tailoring the flesh!  
This loathsome act has never been cited by the Prophet  
nor  
acknowledged by the Hadith!  
Non-existing in Abu Hureyra.  
No Muslim ever preached it!  
Past or present, the Koran never preached it—  
This "Pharaonic mutilation"  
And if I may think of my wedding night,  
awaiting me are caresses, sweet kisses,  
hugging, and love?  
No. Never!  
Awaiting me is pain, suffering and sadness.  
In my wedding bed there I lie groaning,  
curling like a wounded animal, victim of feminine pain.  
At dawn awaiting me—ridicule.  
My mother announces  
yes, she is a virgin!  
When fear gets hold of me  
When anger seizes my body



When hate becomes my company or companion  
 I get feminine advice:  
 It is only feminine pain, they say,  
 and feminine pain perishes like all feminine things!  
 The journey continues, or the struggle continues, as  
 modern historians say!  
 As the good tie of marriage matures  
 As I submit and sorrow subsides  
 My belly becomes like a balloon  
 A glimpse of happiness appears  
 A hope, a new baby, a new life!  
 Ah, a new life endangers my life  
 A baby's birth is death and destruction for me!  
 It is what my grandmother called the three feminine sorrows,  
 and if I may recall, my grandmother said:  
 the day of mutilation, the wedding night and the birth  
 of a baby, are the three feminine sorrows.  
 As the birth bursts from me: And I cry for help,  
 the battered flesh tears again.  
 No mercy, push they say! It is only feminine pain  
 and feminine pain perishes like all feminine things!  
 When the spouse decides to break the good tie  
 when he concludes divorce and desertion,  
 I retire with my wounds.  
 And now, hear my appeal!  
 Appeal for dreams broken  
 Appeal for my right to live as a whole human being  
 Appeal to you and all peace-loving people.  
 Protect, support, give a hand  
 to innocent little girls, who do no harm, trusting and  
 obedient to their parents, elders,  
 and all they know are only smiles.  
 Initiate them to the world of love, not to the world  
 of feminine sorrow!

This poem won the first prize in the poetry competition for female poets of Benadir and was recited during the closing ceremony of the International Seminar on the Eradication of FGM held in Mogadishu, Somalia, in 1988.

Dahabo Elmi Muse, unfortunately, was recently killed in Kismayo.

I have consistently found myself in a very difficult position around the whole issue of sexual abuse and the whole issue of Bill 100 and the sexual abuse of women. We have found ourselves having to come before groups that are predominantly whites, like here, to talk about the issue of female genital mutilation, to talk about the definition of female genital mutilation and the impact of that on women's lives, and know that I'm running the risk of having everybody look at me and every black woman as being part of the perpetrators, and also as being either mutilated or otherwise and wondering what my life is like.

We have been doing this work at Women's Health in Women's Hands for a number of years now. We work with women from the community, particularly women from Somalia, who have been looking at this issue and have been educating us on what are the issues and what needs to be done internationally.

We have participated in international forums in

London, England, around this issue, looking at what is the role of governments in western countries around the issue of female genital mutilation. We recognize a lot of the limitations of sexual abuse as defined as in western terms.

The college of physicians took a position on female genital mutilation at the beginning of 1992, and part of what it said was, "Following a comprehensive review of information received from a variety of sources relating to female 'circumcision, excision and infibulation,' the council has concluded that the performance of any of these procedures by a physician who is licensed in Ontario will be regarded as professional misconduct."

Women's Health in Women's Hands was one of the variety of sources that facilitated the direction that the CPSO took on female genital mutilation. Since then we've been working with women in the community, as I said before. Our position is that female genital mutilation is a critical health issue. It is violence against women, it is a violation of human rights and it is child abuse. But more importantly, as the poet Dahabo expresses it, it is a violation of women's sexuality. Its intent is to curb women's sexuality, the perceived excessive sexuality that it is feared will overwhelm society if women are allowed to be full sexual beings. It also facilitates male dominance in control of women's lives.

The definition of "sexual abuse" as it exists right now in Bill 100 is very problematic. Our main problem with Bill 100 is the limited definition that they use. In Bill 100 and in much of the current western thinking, sexual abuse is predicated on the immediate sexual gratification of the perpetrator. Without this proviso there is no sexual abuse perceived or accepted as having occurred. The definition of "sexual abuse" should be defined solely on the impact as experienced by the victim regardless of whether there has been any sexual pleasure experienced by the perpetrator. Women who have been subjected to various unnecessary procedures to their genitalia experience untold suffering in all aspects of their sexuality, in self-definition, in self-esteem. They have to fight very hard to begin the work of self-advocacy towards a life without pain.

Bill 100 is a very weak piece of legislation, but it is all that women have at the moment to ensure that some of the wrongs we have endured can begin to be addressed. The government proposes to delete the provision in subsection 1(4) which states in part that "the council may make regulations clarifying or extending what constitutes sexual abuse of a patient by a member."

I know that I will not be able to convince anybody in here to extend the definition of "sexual abuse" to include female genital mutilation as part of section 1, but what I'm asking for and what we're asking for in the community is that the provision that allows the regulations to further clarify and to extend the definition of sexual abuse be left in the provisions as it was first put in there so that at least there's a possibility for us being able to work at recognizing and working around the issue of all the other different issues that have an impact on women's sexuality that are perpetrated by the medical establishment and other health professionals.

Those are some of the things that we have as a prob-



lem with the legislation. The issue also of defining sexual abuse as is being proposed by some of the other recommendations that we looked at in terms of the presentations that were made is that they should look at sexual abuse in grades, in levels. If there's something that is somewhat unpleasant, it should not be defined as sexual abuse, it should not be reportable, because it is only somewhat, and it's just a question of a person being insensitive.

We're looking at the impact of sexual abuse on women, lifelong, long after the event has happened, whether it's comments or statements or things that people do to women at the time at which they're experiencing whatever is going on to them at the time that they go to see any health professional. For that to be minimized into being issues of insensitivity by the person and therefore should not be reported is also the same way in which all different governments have minimized the issues of violence against women.

We have watched the federal government blow \$10 million on a panel to talk about violence against women instead of actually doing some services and some provision. I want to urge the committee that is looking at this legislation to ensure that the legislation does not get any weaker than it already is. It has a lot of pieces in it that are missing. Some of the areas that I want to look at, the areas that we had to deal with when we went to some of the consultations around this, make us wonder why we've even been coming back over and over again. We have had to come back and argue and argue against things, for example, like the subrogated issue that was being put in that finally got taken out.

That to me is very problematic. If there is a possibility for any of these kinds of extra pieces to the legislation to be put in by any other body within the health professional body, to change what is in essence a provision that is supposed to try and redress some of the things that women have gone through, then we are constantly going to be coming back over and over again, and that is exhausting. That, to me, is a further sexual abuse. It means that as women what is going on in our lives is not being valued, what is happening to us is not being looked at or examined critically and nobody is taking it very seriously. It has been measured primarily on whether or not the perpetrators have got any pleasure out of this. I don't think that should be what is our criteria for looking at what is sexual abuse and the impact of that on women and what happens to them.

2100

We are looking at, right now, the possibility of trying to come up with a consolidated position and policy from all the various levels of government around the issue of female genital mutilation. We have not been able to find any other piece of legislation that has been willing to look at FGM and put a clear directive and clear legislation that we can work with around doing the education on female genital mutilation and its eradication, in Ontario particularly and probably for the rest of Canada.

What we are seeing is doors closing everywhere we turn for trying to come up with something that will allow for the advocacy and the work that needs to be done in

order for this practice to be eradicated. We are seeing doors closing. Every time we try, we come up against any other particular legislation that is being discussed, whether it's the Criminal Code or this legislation, to say that there has to be a way to ensure that the people who perpetrate these kinds of practices can be dealt with within the system and women can get some redress.

Part of the problem with the CPSO directive is that it is very difficult to find anybody who is willing to come forward from the community to report. This is an issue where there's a lot of education that also needs to be happening. So in a sense I'm really glad that there is the mandatory reporting provision in there and I wish it was stronger than it is right now.

The college, since it put this directive down, has not been able to find anybody guilty of having done this practice, and yet in the community we hear stories and we know that there are women who have been able to find physicians who have charged to do this to their children, to themselves and to other young women in their lives, which the women come forward and ask for.

This, to us, means that the mandatory reporting has to get outside this whole issue of saying it's a cultural issue. The notion that we can talk about the fact that other cultures may tolerate certain violence and others don't is a notion that is very divisive in a multicultural society, it is very divisive in a multiracial society, because there is no society that is more tolerant in terms of if you're looking at what women are going through. There is nothing that makes me, as an African woman, tolerate more pain than a white woman in Canada—nothing. There's nothing that predisposes me to tolerance for pain and violence in my life.

So to look at this and say other societies tolerate, culturally, violence against women in different ways that this society would not tolerate is a violation in itself. It assumes that the societies that are male-dominant and the definitions they use to define what is abuse and what is not abuse are what stands for any other society that looks out here. This society also tolerates a very high level of violence against women. There was a judge in Victoria, BC, who decided that a three-year-old had a history of sexually seducing men, in this society that is not tolerant of sexual abuse and violence against women. So we have to look at that and look at the racism in some of those statements and what we're doing and how we're doing the work.

This is what I would like to see: I would like to see the provision that allows for further clarification and extension of the definition of sexual abuse remain in the legislation as it stands to allow us to be able to work at a clear definition that everybody can work with.

**The Vice-Chair:** Thank you for your presentation. I'm sorry, time does not allow for questions. We're at the end of our time, but we appreciate your presentation.

**Ms Keyi:** I'm not surprised.

**The Vice-Chair:** Does someone have a question?

**Ms Keyi:** No, you said time does not allow, and I'm used to that reaction too.

**The Vice-Chair:** Everyone is time-allocated.

**Ms Keyi:** Time never allows to discuss issues that are—

**The Vice-Chair:** We wish that all of the deputants had more time for both presentation and questions and discussion.

**Ms Keyi:** Mr Eddy, I was supposed to present at 8:15. I was kept here until 9 o'clock.

**The Vice-Chair:** Yes, I know you were later—

**Ms Keyi:** I made my presentation and as soon as I finished you did not ask any of these members in here if they had any questions. You have decided that the time does not allow.

**The Vice-Chair:** I'm sorry.

**Ms Keyi:** That's okay.

**The Vice-Chair:** Just a moment. They indicate prior to the completion and during the presentation if they have questions. That happens all the time.

**Ms Keyi:** Yes, it happens all the time, especially when we're debating issues that do not pertain to the mainstream society.

**The Vice-Chair:** If anyone has a question they would like to ask the deputant, you may proceed at this time. Are there any questions? Thank you.

Next presenter please, the Respiratory Therapy Society of Ontario. Would the presenters please come forward, introduce—

**Ms Keyi:** I would like to—

**The Vice-Chair:** I'm sorry, I'm in the middle of sentence. Would the presenters like to come—

**Ms Keyi:** I would like this to go on record.

**The Vice-Chair:** What is your statement?

**Ms Keyi:** It doesn't matter what we say and the work we're doing and the kind of pain that women are going through in this society and in any other part of the world. When we come forward, it's at great risk to our own lives to present something to you to have you even listen to us.

You tell me you don't have the time. I'm used to that too, and that has been always what my life has been like. It seems as if all the things that I have done here—to find that I can sit in here and take my time and my energy and the pain that women have gone through in my community and come here and run this risk and have you tell me you don't even have the time to ask me what it is you don't understand about what I am saying is very dismissive. It's very, very dismissive.

**The Vice-Chair:** Thank you for your presentation.

**Ms Keyi:** No, don't thank me. I'm sure you didn't want to hear it.

**The Vice-Chair:** That's not correct.

RESPIRATORY THERAPY SOCIETY OF ONTARIO

**The Vice-Chair:** Would the next presenters please come forward, introduce yourselves and then proceed with your presentation.

**Mr Sean Kenny:** My name is Sean Kenny. I'm the president-elect of the Respiratory Therapy Society of Ontario.

**The Vice-Chair:** I'm sorry to inform you that we are under time restraints. We hope to have 15 minutes. If it does allow time for questions, we'll have it. Unfortunately, if it does not, then there isn't time for questions. I have to perform that way.

**Mr Kenny:** First of all, the Respiratory Therapy Society of Ontario was formed in 1972 and represents the majority of registered respiratory therapists in the province of Ontario. Registered respiratory therapists assist in the diagnosis, treatment and promotion of the wellbeing and quality of life of patients with respiratory and associated disorders.

The practice of respiratory therapy has been defined as "the providing of oxygen therapy, cardiorespiratory equipment monitoring and the assessment and treatment of cardiorespiratory and associated disorders to maintain or restore ventilation."

Registered respiratory therapists are one of the newly regulated professions under the Regulated Health Professions Act. Members of our association work in the institutional setting, employed by the vast majority of hospitals within the province, and the community-based setting, working for most home respiratory suppliers in Ontario in sales and in the field of education.

The Respiratory Therapy Society of Ontario fully supports the principle of Bill 100; that is, to define what constitutes sexual abuse, to identify sexual abusers who are members of Ontario's health professions, to develop a responsive discipline process to ensure punishment of abusers and to ensure sensitive and compassionate treatment of survivors. However, we do have a number of concerns with the legislation, in that while the objectives are clear, the means to achieve these objectives may not be adequate.

More specifically, we are concerned with the following: firstly, the definition of sexual abuse; secondly, mandatory reporting; and thirdly, program for funding counselling.

Concerns with the definition of sexual abuse: Currently, the ministry is planning on implementing one definition of sexual abuse for all professions. The Respiratory Therapy Society of Ontario recognizes the difficulty in defining sexual abuse, particularly with respect to remarks and/or behaviour, in that the definition will be subjective in nature and therefore difficult to interpret. However, this definition must be more objectively outlined within the legislation to ensure that abuse is no longer open to interpretation.

The Respiratory Therapy Society of Ontario also believes that there must be a mechanism for clarifying what constitutes sexual abuse within each profession. However, the mechanism that was contained within the legislation when it was initially introduced allowing for extension or clarification of what constituted abuse has been removed by the government. While we agree that there is no need for a mechanism to extend the definition of abuse, the need for clarification within the regulations for individual colleges is essential.

2110

Concerns with mandatory reporting: The Respiratory



Therapy Society of Ontario supports the requirement for mandatory reporting of members of the same college, as members of the same profession may be in one of the best positions to evaluate the actions of a colleague in determining whether the actions of that colleague would constitute sexual abuse. Members of the same college would have a firm understanding of the scope of practice of the profession and therefore what constitutes appropriate and inappropriate actions.

However, the RTSO is concerned with the requirement for mandatory reporting of members of another college for the following reasons: First, members of a college may not have a clear understanding of the scope of practice of another profession and should not be judging the actions of another health profession based on limited or non-existent knowledge. This process would be arbitrary and would not serve the interests of the patient.

Second, the requirement to report members of other professions, some of whom may be in positions of authority over others, may jeopardize the standing of these health care professionals within their place of employment. To date, we have not seen any evidence that the ministry has developed an enforceable mechanism to ensure that the rights of all professions will be protected in this regard. As a result, we would recommend the removal of this requirement.

We are also completely opposed to the requirement for treating professionals to report their health care patients to the patient's respective college. We believe this to be a contravention of our rights and could potentially result in an increase in sexual abuse, as professionals will no longer have the freedom to seek treatment without fear of reprisal.

Concerns with funding counselling: The RTSO supports the principle of funding for counselling of survivors of sexual abuse by health care professionals while under the professionals' care. The RTSO, however, does not believe that the colleges should be required to fund treatment for counselling for survivors of sexual abuse. There is no other self-regulating profession in Ontario that carries that burden. For many of the smaller professions, this requirement could even prove to be financially crippling to the functioning of their college.

With respect to funding the program, we would recommend one of the following options: First, that fines levied on abusing professionals be deposited into a specific college account and that these fines pay for the counselling of survivors, or, second, that the fines continue to be deposited to the general revenue accounts and that the funds for treatment and counselling be provided out of these general revenues.

In conclusion, the Respiratory Therapy Society of Ontario applauds the work of the government in introducing legislation to deal with the issue of abuse of patients by health care professionals. The Respiratory Therapy Society of Ontario has acknowledged the problem and for the past several years has been working with the government, health care providers, survivors and their representatives to address this issue.

We fully support the initiative undertaken by the government and fundamentally believe that this legisla-

tion, with amendments to the sections on definitions of "sexual abuse," "mandatory reporting" and "program for funding counselling," will ensure that patients have the protection they deserve and that it will be the first step in achieving the goal of the elimination of sexual abuse of patients by health care professionals.

**The Vice-Chair:** Does that conclude the presentation? Thank you. Ms O'Neill had indicated during the presentation that she had a question to ask.

**Mrs O'Neill:** You have brought a different perspective on the mandatory reporting. I wonder if you would expand a little on how you could see the legislation improved. In your statement, "We have not seen any evidence that the ministry has developed enforceable mechanisms to ensure that the rights of all professions will be protected in this regard," you must have some reasons for saying that. Hopefully, you have some ideas on how that could be accomplished. As you see if you've been sitting here a while tonight, mandatory reporting is a rather crucial element of this particular piece of legislation.

**Mr Kenny:** Yes, and we do believe that mandatory reporting within the members of the same college is important and essential. The problem we see with regard to the existing legislation and how we might suggest an improvement: I submit it may be impossible to do more than what has already been done in terms of protection of the rights within an employment situation, because certainly the clause is within the legislation that states that your employment situation cannot be jeopardized. But the fact is that in working situations, you have people who have positions of authority over other individuals. It's our feeling that to have mandatory reporting between colleges, there is no way to protect that individual who might be doing the reporting against a colleague who is in a position of authority over that person. That's why we propose that it be dropped from the legislation.

**Mrs O'Neill:** I would surely find that would make this bill very, very weak if it came forward. If that's the case, this bill is not going to serve its purpose, because I think—and I have heard quite a few presentations on this point—there is a lot of interdisciplinary contact, communication, trust, and mistrust, that are going to have to be part of the way this bill is going to unfold if it's going to be meaningful and is going to come alive in the community. If we remove this part of the bill in its totality, and that's what you're asking for, I really do not see how this bill can operate.

**Mr John Bell:** I'm John Bell, the past president of this society. I think Sean is stating more that what might happen is that the worker could be placed in a situation of being in conflict with the supervisor, employer etc, which is understandable and will happen in those cases. What could possibly be written in to alleviate something like that might be protection of that individual in that type of situation versus completely withdrawing it. I know we've asked for withdrawal in that case, but we certainly would consider something of that nature to protect the rights of the individual versus completely withdrawing that from the bill.

**Mrs O'Neill:** So you feel a regulation needs to be



particularly strong in that area. I would tend to agree with you. I suppose it would compare to the civil service whistleblowing legislation, but much more serious, in my humble opinion.

**Mr Bell:** I agree.

**Mrs Haslam:** My question was along similar lines, and I fully agree with my colleague that through the presentations we've heard tonight, victims are asking that we do this and do it quickly. They're tired of waiting for this legislation. There have been a lot of consultation meetings—April, July, August, October; many phone calls to groups like yours; consultation; preconsultation; "What do you think about this type of legislation?" I think erring on the side of the victims is where I would rather be right now in this legislation.

My concern was on page 12. You said, "Not only does this requirement infringe on the right of professionals, it will also reduce the number of professionals seeking treatment." We're hearing in consultation that in the past this particular function—I'm talking about psychoanalysis right now—when you talk about cross-disciplinary has been seen as a way of getting out of being reported and having to pay for the occurrence of sexual abuse, "I'm receiving help for this problem; therefore, I don't need to have disciplinary action."

2120

Maybe that's just a comment, but that's one thing I'm hearing. You're saying it will reduce the number of professionals seeking treatment. We're talking about filing a report where they have reasonable grounds. I know they've looked at the idea of having a statement come from a professional along with that report that says they are getting help and it is curable, and therefore that would be taken into consideration by the college when it is looking at these incidents.

I feel the ministry has heard some of the concerns around the mandatory reporting and has tried to bring a balance in. On one side, you have the victim saying, "If you don't have that type of reporting, it's very weak," as my colleague has said. On the other hand, you have professionals saying, "We do have to have some leeway there to say that there is help and that we have input into that mandatory reporting."

Maybe it's not a question, but I feel that comment was very necessary, given this particular part of your presentation.

**Mr Wessinger:** I'd like to make a clarification about the aspect of protection for a person reporting. In fact, in the bill, section 92.1, there's a provision that, "No person shall do anything, or refrain from doing anything, relating to another person's employment or to a contract providing for the provision of services by that other person in retaliation for that other person filing a report or making a complaint, as long as the report was filed, or the complaint was made, in good faith."

As long as the complaint was made in good faith, there is that protection.

**The Vice-Chair:** This completes the question period. Thank you for your presentation.

#### TRANSITIONAL COUNCIL FOR THE COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

**The Vice-Chair:** The Transitional Council for the College of Dental Hygienists of Ontario is next. Please introduce yourselves and proceed with your presentation when you're prepared.

**Ms Linda Strevens:** I'm Linda Strevens, the registrar for the College of Dental Hygienists of Ontario. On my right is Mrs Jane Rogers, one of our professional members of council and leader of the working group that has been dealing specifically with Bill 100. Thank you very much for your time this evening. I do realize it is getting on.

The College of Dental Hygienists of Ontario will, upon proclamation of the Regulated Health Professions Act, be responsible for regulating the profession of dental hygiene. To date, the Royal College of Dental Surgeons of Ontario has been the governing body of dental hygienists. Although we will become self-regulating for the first time as a new college, we have had regulation for over 40 years. Our membership is composed of 4,900 dental hygienists, with approximately 1% being male. It is the mandate of the college to regulate the practice of the profession and to govern the members in accordance with the RHPA. As such, we must investigate complaints of sexual abuse and discipline guilty members. Thus, the need for effective, workable and enforceable legislation is critical.

The transitional council supports the goal of zero tolerance. We have been actively involved with other councils towards developing a sexual abuse prevention plan and have attended meetings that brought together survivors of sexual abuse with advocacy groups, governing bodies and professional associations. These meetings have provided us with a better understanding of the survivors' concerns.

We strongly support the recommendations that were made last week to this committee in the submission by the Coalition of Regulatory Colleges and transitional councils. Many of these points are contained within the contents of our written submission. Mrs Rogers will now briefly outline some of the specific points as they relate to the profession of dental hygiene.

**Mrs Jane Rogers:** Our position tonight will focus on the definition, mandatory reporting and funding.

The definition: It's very important that the definition of sexual abuse be as clear and concise as possible, especially clause (c). It will be used—and I'm speaking of the whole definition—to define conduct that can lead to disciplinary proceedings and to tell practitioners what they must report.

A practitioner who has reasonable grounds to believe a regulated professional is abusing or has sexually abused a patient must report that practitioner to his or her college or be subject to a \$25,000 fine.

This sexual abuse includes "behaviour or remarks of a sexual nature." The ministry's suggestion to add the words "demeaning, seductive or exploitative" make this definition very subjective. It forces the third-party practitioner to make a judgement about what the patient

might believe to be demeaning etc. If practitioners are unsure about what is required, they will either report nothing and the abuser will continue on, or they will report everything and colleges will be swamped and the abuse will carry on until the system catches up.

We support the coalition proposal to add a subsection (4), as outlined in their submission on page 7:

"(4) For the purposes of subsection (3), 'sexual nature' does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided."

Our council supports the Ministry of Health proposal to remove from the mandatory reporting requirement the cross-professional reporting of incompetence, incapacity and misconduct.

Under funding: The CDHO council accepts the responsibility of assisting complainants through the complaints and discipline process. We agree that funding for therapy and counselling should be available. However, we do not believe colleges should be required to compensate victims. This legislation encompasses a broad range of practitioners with varying degrees of earning power. Innocent members of a college should not be penalized for the sins of one guilty member. We don't believe that is what self-regulation is about.

As a member of the Coalition of Regulatory Colleges and transitional councils, we have discussed alternatives at length. The coalition presentation has outlined suggestions that we agree with. More time is needed to devise a plan that will be satisfactory to everyone.

I would make a comment. This evening it was mentioned that we've had two years to work on that, and we really haven't had two years. Most of us—and I won't say all of us—only became aware of Bill 100 in October 1992, not 1991. It has been a very busy year for a lot of us, and the sexual abuse process has taken a lot of our time. So I think when you hear us say we need more time, it's because we have been overwhelmed by a lot of things. Thank you very much for your attention.

**The Vice-Chair:** Ms Haeck indicated she had a question.

**Ms Haeck:** I'm interested in your comment regarding funding. There is a permissive nature to the funding proposal in that a number of the colleges can actually pool their resources; it's not a matter of just keeping it within the bailiwick of each separate college. You have, as you've indicated here, 4,900 dental hygienists. I would suspect—and I've asked this of at least one other group that's come before us—that you've probably not had a case, but you can correct me if I am wrong, you have not really been inundated with these types of problems.

**Mrs Rogers:** No, that's correct.

**Ms Haeck:** So that in reality, if you sort of used the formula that is being prepared, you would really only need to have \$10,000 set aside to deal with a possible problem. This would not in essence be a financial hardship as outlined. I would suspect that with 4,900 members, with just the dues process and what have you, in all likelihood that particular money should be able to be found and put aside. Am I extrapolating too much here?

**Mrs Rogers:** No, I think you're correct. We have no experience with a sexual abuse complaint. However, if things do carry on and, for instance, if you had one member who is found guilty of sexual abuse and there is more than one complainant in the case, you're then talking about multiples of \$10,000. I think what we're trying to say is that it's difficult for the newer colleges especially to grasp the whole thing. I think that it's because of everything that's been piled on them.

The one concern we had was, with the conflict of interest—and I think a number of other groups—if you have a disciplinary panel that is hearing a case and it finds that the practitioner is innocent, and we've mentioned this in our brief, we would hate to see that the panel would be accused of finding the person innocent to avoid the \$10,000.

**2130**

That's where your conflict comes. You're having a panel deciding guilt and then having to pay out a \$10,000 therapy funding. That could happen. Then your panel would have to live with that accusation that they had a conflict, that they were not looking at the evidence. There are innocent practitioners; there are people innocent of being charged.

**Ms Haeck:** No, I couldn't argue with that particular observation. I would like to at this point refer Ms Rogers's—am I correct—comment to the parliamentary assistant, if I might, with regard to the fact that I think she raises an interesting point that I don't believe I've heard in exactly the same way up until this point. If in fact the practitioner, having gone through the process, is found innocent and moneys have been dispensed, what are the remedies in that regard?

**Mr Wessinger:** I will ask legal counsel to—

**Ms Christine Henderson:** I'm not exactly clear what you're asking.

**Ms Haeck:** I think the concern that Ms Rogers raises is that after there is an allegation, it goes through the discipline panel and the particular practitioner is then found innocent. However, there have been moneys dispensed on behalf of the college. Now, please correct me if I am—

**Mrs Rogers:** Actually, you're talking about two things and we have discussed both. The example I was using was that none of the \$10,000 had been disbursed but the practitioner had been found innocent. The panel could be accused, especially by advocacy groups, of allowing the practitioner to go free to avoid the \$10,000 payment, and that's where the conflict comes.

However, we have discussed the fact that you probably would start paying some of the money for therapy for your complainant as they're going through the process. Certainly at the coalition level at this point in time, there was no indication that anybody would ask for that money back. It would just be money well spent at the time because you were aiding a person going through the process. So it is actually two different things.

**Ms Haeck:** Okay. If I've misheard, I apologize and if there are any clarifications that you can offer—

**Mr Wessinger:** No, unless you would like to—



**Ms Christine Henderson:** I would simply say that this kind of argument, that a panel would be conflicted in this way, I think really goes to the heart of self-governance, because I believe the public and certainly the ministry has provided the privilege of self-governance with the understanding that the tribunals will handle themselves with the utmost integrity.

The panels make very difficult decisions. It's part of the whole underlying principles of self-governance that a panel conduct itself in a way that is responsible and in a way that protects the public interest.

**Mrs Rogers:** I agree with you but I can see the occasion where groups will stand up and say, "Oh, they were guilty."

**Ms Christine Henderson:** Similarly, I think with the new provisions under the government's amendments that would provide a college with a far greater degree to collect its costs: its legal costs, its costs of the hearing, its investigatory costs—one of the colleges tells us that these costs can amount to well over \$100,000. Arguably, that would balance your conflict that you raised on the other side.

**Mrs Rogers:** Good point.

**Ms Christine Henderson:** Also, I might add that the government's amendments also now provide that the college panel will have the ability to require the perpetrator to pay into the fund the amount expended for the purposes of therapy and counselling of the eligible person. You will be able to, up front, require security to secure that amount. As you know as well—which has also been an issue raised by some of the presenters—there's no intention for OHIP reimbursement or other kinds of funding that the government now covers: women's clinics etc, coverage that a private insurer would otherwise cover, as well as the perpetrator's contribution. So in other words, the fallback to the fund as required through the collective responsibility of the members is the last resort.

**Ms Haeck:** I hope that allays some of the concerns. We're always thankful for legal counsel's contribution.

**The Vice-Chair:** There was no other indication of a question. Did anyone have a question? If not, thank you for your presentation.

#### SURVIVORS OF MEDICAL ABUSE

**The Vice-Chair:** The next presentation is by the Survivors of Medical Abuse. Would the representatives come forward, please, and introduce yourselves and proceed with your presentation when you're ready.

**Ms MacPherson:** Josie MacPherson, facilitator, Survivors of Medical Abuse.

**Ms Sharon Danley:** Sharon Danley, cofacilitator of Survivors of Medical Abuse.

**Ms Velma Demerson:** Velma Demerson, speaking for Survivors of Medical Abuse.

I'm speaking on female genital mutilation. It's probably not as interesting a subject; it doesn't deal with the finer points of law. It deals with sexual abuse in a sense that a lot of us here have been sexually abused. It's an emotional thing. Remember, it's emotions that cause

revolutions. Oops, there goes the organization.

The matter of female genital mutilation was mentioned briefly by Metrac and it was mentioned again just recently by Vuyisuba Keyi. The ministry has heard it before. At one point we attended a session over at the Chestnut Hotel, and when female genital mutilation wasn't going to be looked at, the women all walked out. Since that time, nothing was done that I ever heard about it and it's just disappeared.

This practice is identified with particular ethnic minorities. However, in our multicultural society we can expect to absorb both beneficial and negative customs. The federal government has defined female genital mutilation as aggravated assault. The sexual component is thus ignored in the public mind. It is our responsibility to name this offence so the public will be on the alert. Burying it in aggravated assault misrepresents this purely sexual abuse. It is buried away under myriad offences. There is no comparison. It is a particular offence.

We do not want a wounded woman coming forward and berating us for not doing what we could when we had the opportunity. The time is now. Not only are we concerned with the irreparable damage to a female child, but the eventuality of a backlash to any ethnic group identified with this sexual assault.

#### 2140

Mandatory reporting of regulatory health care professionals needs to be expanded to inmates in closed institutions. On page 006 of the submission by the National Association of Women and the Law, it mentions that vulnerability to abuse is directly related to social inequalities such as those experienced by first nations women, black women, women of colour, elderly women, immigrant women, refugee women, sex-trade workers, lesbians and women with disabilities. I would like to add to this persons who are inmates in institutions over a period of time, such as prisons, psychiatric institutions and nursing homes.

We must open up all avenues to public scrutiny. We have all seen the laxness in the past. It is unacceptable that a report from the Grandview girls' school is being withheld from public view. If we don't know the organization that has been going on—with all the social workers who have been going into these places, the psychiatrists, the professional health care workers, we yet have all these grown persons coming along and telling us these horror stories. It's disgraceful to the province and it's disgraceful to the nation.

A doctor who does not report such abuse must be considered as an accessory to it. We don't know if any of these abuses have been reported, if the bureaucracies have hidden them. That's why we need any report that might be of service. How can we change this situation if we don't have access to a defective organization within the institution?

I will give you a slight example here of a case which just came to mind. A woman was in one of our reformatories—it was in the news just lately—and she had terminal cancer. There was a suggestion that a judge said she should be let out. She was in for shoplifting. She had



about three months, so her lawyer was trying to get her out. I wrote to the Health minister about this. The minister answered that the provision of health care to inmates of penal institutions is beyond the mandate of the Ministry of Health. She sent my letter to the Solicitor General's office, the corrections branch, and they advised that the patient was being carefully monitored by their health care staff.

My original letter had asked that the patient be given a doctor of her choice, and I was advised that this did in fact happen; she was given the doctor of her choice. However, the prison said she could have a second opinion, presuming that the prison doctor was the first opinion. What happened there was that she apparently decided she had a right to refuse treatment and she wouldn't give any information to the prison doctor. She refused to allow them to have her records from the hospital, so they couldn't give her the care they suggested, because they didn't know what was wrong with her, and eventually they let her go.

This is a matter of the situation that happens within an institution, and I speak from personal knowledge of this. I had been in a reformatory many, many years ago and the situation is such that the doctor was abusing her patients. It was a woman. You might call it sexual abuse if you want to.

On one occasion I was transferred there with 46 other inmates from a girls' home. We were all lined up and we had to watch the doctor. We went right into the examining room, because the doctor was in a hurry. She had to get through all of us in one morning. We had to be examined sexually, which seemed to be the whole thing about that prison. The whole idea was that nothing else really counted that was wrong with you.

This woman beside me, whom I knew, a 24-year-old woman, quite heavy-set, was in the later stages of pregnancy. She got on the table and the doctor proceeded to examine her internally and twisted the instrument around inside her. She started to cry and the doctor didn't pay much heed to it. Eventually she got down.

I got on the table next. I didn't get on the right way. I was losing time. The doctor had told us how to get on there. I had to stand in the corner. I spoke to a lawyer about that and he said, "You were being set up right from the beginning."

This female doctor, by the way, had a very strong military background. Some of the girls complained that she didn't cool off the instrument before inserting it and it burned them sometimes.

The doctor was reporting to the health department by way of reports. The inmates had no other way of complaining about any of their treatment unless they went to the superintendent. The superintendent didn't have as much power as the doctor. Also, she didn't have the knowledge of the doctor. So nothing was done. This situation there continued for a long time and it's been somewhat documented.

What I'm saying is that this is where mandatory reporting comes in and where, in this particular instance, there have to be advocates to go into these places and

talk to people, whether it's in psychiatric institutions, in nursing homes, in any closed facility, so there can be some outlet for the patients to report. On the other hand, patients are afraid to report because there might be recriminations. Whoever goes in, of course, it's incumbent on them to do mandatory reporting. Any health professional who happens to go in there needs to report.

**2150**

I don't know why health professionals haven't reported this situation that's existed in Ontario for the past 50 years or so. I don't know why. Why is there no investigation?

But the thing is, there has to be mandatory reporting by the doctor if he sees anything within an institution that is improper. Also, this is something apart from reporting on professionals. There's no excuse why they can't, because a doctor uses his judgement all the time when he's dealing with patients. Why can't he use his judgement in dealing with sexually abused patients and make a report?

In terms of confidentiality, it so happens that there is a precedent, and that is the venereal diseases act of 1937, which indicated that persons who didn't want to reveal they had a disease could have a number, and this number was sent to the health department. It may have been to get drugs, because free drugs were given out. So the person was very well protected within the system, except perhaps if a person went to a clinic or some other place, that it would be a class distinction. In some instances there were complaints that the government wasn't getting the statistics, because in some areas nobody had venereal disease.

I'd like to close with one thing here on which we are all agreed, and that is that in the definition of "sexual abuse," there's a section there that says that where sexual abuse can't be defined, the minister will make a decision, and this will be presented to the Lieutenant Governor for passage. We would suggest that an advisory council be set up to advise the ministry, including survivors.

**The Vice-Chair:** Thank you. Ms O'Neill had indicated during the presentation—

**Mrs O'Neill:** Ms Demerson—is that correct?

**Ms Demerson:** Yes.

**Mrs O'Neill:** I think you've done a real service tonight. I want you to know that. You're one of the few who have brought up institutional abuse, and I'm very happy that you've brought up two things that I'm very interested in and I've done some work in.

The Grandview situation—I presume where you were resident is similar to that?

**Ms Demerson:** No, it wasn't similar.

**Mrs O'Neill:** It wasn't similar. All right. I'm sorry I made that presumption. But that's three years in investigation. We've had two charges laid, over 100 witnesses come forward, and the persons have been people who are in positions of authority, one of them being a medical authority.

**Ms Demerson:** I was wondering why the report hasn't been issued to the public.

**Mrs O'Neill:** Unfortunately, the courts have come down against us on that decision after two appeals by this government. In any case, that hopefully will move forward in the new year, but we are certainly feeling quite a bit of foot-dragging, particularly in the investigations into abuse, on that, and would like to see that move faster.

The other area that I'm particularly interested in that you've mentioned that no one has is the abuse of seniors in institutions. That certainly, I think, could centre more around women since there are more women in institutions for seniors than there are men.

Then your very poignant story about the penal system—I find that people like yourself who have suffered abuse tend to reach out to those who are being abused now, and for that I give you a great deal of credit. That can't be easy because it must mean reliving some of your own experiences.

I'd ask you to say a little more about senior abuse and how you feel this bill—and particularly after your testimony, I think it is but a first step—could be improved or what parts of it could most affect senior abuse in institutions.

**Ms Demerson:** I think it's going to be difficult to separate seniors from others. As a matter of fact, I saw a seniors' TV program in which it was brought out that seniors don't want to be considered as different from anybody else. They don't want this discrimination that they're not included, like in Bill 100, for instance.

Also there's this fragmentation with children, like child abuse. Some of those children could have been here today. I mean, they grow up. Not only that, but children who reach 18 are still children, but they can be pretty vocal. They've been watching TV and some of them are well educated so they could speak for themselves. I don't think there should be any fragmentation.

**Mrs O'Neill:** The reason I mentioned seniors is because you mentioned advocates, and having recently been involved with a senior, there are so many seniors who are very isolated in institutions.

**Ms Demerson:** Yes, seniors particularly are rather fearful. They're fearful of the care they're getting. They don't want to report anybody, so someone has to do it for them.

**Mrs Cunningham:** I've really appreciated your presentation—it's quite compelling—and your two supporters who spoke earlier, at least one of them.

Every once in a while before this committee we find out the real reasons for a lot of us being here and what we do. It is a team effort, isn't it, that makes changes for others? I just wanted to thank you. I know it must have been difficult, but we very much appreciated it.

**Mrs Haslam:** I'll just say "ditto" because I think it becomes redundant.

When you talk about seniors, I too am very interested in seniors. I'm very pleased to see that the Advocacy Act came in, which will help those in institutions. We were really pleased to bring that in, and consent to treatment and all of those aspects around the new Advocacy Act we brought in.

I would hazard a guess that you are very much in favour of mandatory reporting.

**Ms Demerson:** Yes.

**Mrs Haslam:** Do you feel there should be exemptions for some professional group out there?

**Ms Demerson:** No, I don't think so. We have to trust a person's judgement. There might be some risks involved, but it doesn't matter what you do; that's going to happen anyway.

**Mrs Haslam:** Those are my two questions. Thank you again, ladies.

**The Vice-Chair:** Thank you.

2200

#### OUT OF PATIENTS ADVOCACY NETWORK

**The Vice-Chair:** The next presentation is by Out of Patients Advocacy Network. Please introduce yourself and proceed with your presentation when you're ready.

**Ms Susan Vella:** My name is Susan Vella and I am legal counsel to the Out of Patients Advocacy Network. As part of my personal background, I am a lawyer who practises in the area of civil sexual assault and represent survivors, including the Grandview survivors, in which case there are allegations of abuse in an institutional context surrounding abuse by the mental health profession.

The Out of Patients Advocacy Network, you will see in our brief, which should be distributed to you, is a coalition largely of survivors of sexual abuse at the hands of the health care profession.

You will also note that in our brief we have made 11 specific recommendations, including draft legislation and analysis drawn from legal jurisprudence and Ontario legislation in support of our recommendations.

I think we have to remember why it is we're all here and why we have a Bill 100. We have heard that there are too many incidents of sexual abuse in the health profession to allow these situations to be dealt with on a case-by-case basis. It is a societal problem which requires a societal response, and the proposed legislation constitutes our societal response. Also, society recognizes the social utility in preserving the trust element which permeates the health care profession in the professional-and-patient relationship.

In order for the health care system to be effective, it is necessary that health care professionals retain the trust of the patients they care for; in other words, it is important that they retain their fiduciary character. The fiduciary relationship is one which connotes a relationship in which the fiduciary holds a position of power and authority and trust over the beneficiary, who is the recipient of that fiduciary's expertise and advice.

Importantly, the law attaches specific obligations to fiduciary relationships. It requires the fiduciary to be loyal, to have good faith and to avoid, at all costs, self-interest and conflict of interest. It is important to note that the Supreme Court of Canada has already recognized that a doctor-patient relationship is inherently fiduciary.

The goal of the health care professional of course is to promote and facilitate the wellbeing of their patients. As



a fiduciary, a health care professional must avoid conflict of interest and self-interest. When a health care professional engages in sexual behaviour and sexually abusive conduct towards his patient, the fiduciary has violated both of his obligations. He has engaged in an activity which involves self-interest and he has also violated his positive duty to promote and facilitate the wellbeing of the patient.

We all recognize that physical touching is essential to some of the work done by health care professionals, and we all recognize that the patient must be able to trust the health care professional to allow that physical touching. However, when the health care professional exploits that trust by turning physical touching into sexual touching, they have undermined the effectiveness of the entire health care system.

Importantly, certain legal conclusions flow from a breach of a fiduciary duty; in this case, from the sexually abusive conduct by a health care professional towards his patient. The first is that the patient cannot, at law, be deemed to have consented to the violation of that trust. The second is that the fiduciary must be held accountable and answerable for all of the harms and injuries, personal and economic, which flow from that breach. Bill 100 implicitly recognizes that health care professionals are fiduciaries and prescribes an administrative process to deal with determining the breach and setting out the health care professional's responsibility and accountability for that breach.

We have made several recommendations in our brief in the following areas: the need for a preamble; clarifying the definition of sexual abuse to include sexual harassment; the need for mandatory standing for complainants; the inadmissibility of evidence pertaining to a complainant's past sexual history; the need for long-term compensation and interim therapy awards; the need to characterize sexually abusive conduct as incompetence as well as professional misconduct; and the need to provide a definition of "patient" in the legislation which will, in certain circumstances, include a former patient. The recommendations are summarized in the appendix to our brief for your ease of reference.

With respect to the preamble, as you have heard, the preamble is the opportunity for the government to set out the context of this legislation. It will be used as an interpretative tool for the discipline panels and the courts to interpret in an appropriate manner the legislation. We have set out a preamble which largely adopts that set out in the brief by the National Association of Women and the Law.

With respect to the definition of "sexually abusive conduct," we have heard that there are concerns about clause 1(3)(c), which pertains to remarks and behaviour. We believe that part of the confusion arises from the fact that it has been labelled "sexual abuse," which to many people means some kind of physical touching, when in fact what it really connotes is sexual harassment. By calling this "sexual harassment" we will eliminate the uncertainty, because there is a whole body of jurisprudence which defines what sexual harassment is and what it isn't. It will also assist us in responding to those

complaints that a single, isolated comment will subject the professional to the rigours of a discipline panel in all cases.

We all know that in the Hryciuk inquiry, Madam Justice MacFarland indicated that certain of the verbally harassing statements by the judge, when taken in isolation, may not in and of themselves warrant the sanction of removal of that judge. However, when viewed as a pattern of conduct, it constituted conduct tantamount to sexual harassment and accordingly did justify removal from the bench, which is the severest sanction, of course, that can be applied to a judge.

We have suggested specific drafting of legislation, which I will not repeat at this time, but it's found on page 8 of our brief. We also support the power, however, of the colleges to enact regulations, which is a quick way of responding to ambiguities when and if they should arise.

We also adopt the use of an objective standard in defining what constitutes sexual abuse and sexual harassment, but from the perspective of the complainant. In our brief we do set out jurisprudence in which sexual harassment cases adopt that definition and standard. Again, we have provided you with specifically drafted legislation to accomplish that objective.

On the issue of standing, it is absolutely fundamental that there be accorded mandatory full standing to complainants. There is ample precedent in our Ontario legislation right now for this status. The Ontario Human Rights Code provides specifically that the complainant, in addition to the commission, which does have carriage of the prosecution of the complaint, shall be accorded full rights of standing. When we are dealing with complaints of sexual abuse, credibility will always be at issue, and therefore the complainant deserves the voice to have her personal interests represented separately at the hearing.

## 2210

On the note of the second part of the standing, which is for what we know as "friends of the court," this is discretionary standing to be provided where a body or person has special expertise which will assist the tribunal in making an appropriate decision. We maintain that this should remain at the discretion of the panel, as it is with the courts.

On the note of admissibility of evidence of past sexual conduct: This is very important. As we have learned from our experience with the rape shield legislation, the reason why many legitimate survivors do not come forward with complaints of sexual abuse is because they are terrified that irrelevant evidence of past sexual conduct will be raised against them.

I draw you back to my comments on fiduciary relationships and what that means. It means that the defence of consent, to which evidence surrounding past sexual conduct is generally used, is not an option for the respondent. Given that it is not an option, there is no reason and no circumstances under which evidence of past sexual conduct will be relevant, and therefore it ought not to be admissible. Again, we have provided you with specifically drafted legislation to accomplish that objective.



On the note of mandatory reporting: Yes, we must have it. It makes no difference what profession the witnessing health care professional belongs to.

Let us remember what mandatory reporting does. It does not lead to an automatic disciplinary hearing. All it does is raise concern or draw to the attention of the college a potential problem. If the college finds that there is no merit or insufficient merit to the complaint, it will not go forward to a panel.

However, what will be accomplished is the comprisal of a record of what may become a pattern of misbehaviour, much like in the Hryciuk case. It may be that the first complaint won't warrant a panel, but by the time we get to the third or the fourth, there is sufficient evidence to warrant a discipline proceeding.

I've also heard that there have been concerns about confidentiality on behalf of the psychiatric community that, if they are compelled to make a report when their patient has asked them not to violate their trust relationship and go forward, this puts them in a conflict vis-à-vis the mandatory reporting requirement.

Our recommendation is that the reports must still be made to the college, however, with the qualifier that it was not in the patient's wellbeing to advance this matter to a complaint. That way it will not force a prospective complainant to go forward until she is ready to go forward.

What it will do, however, is again build that record that I've been talking about. Maybe a second complaint will come forward, or a third or a fourth. The college will have to take that second or third complaint more seriously, having some knowledge that there's already been concern raised about this professional.

On the note of compensation for survivors of sexual abuse: The current legislation is not broad enough; it should provide for full compensation. There is precedent specifically in the Compensation for Victims of Crime Act. We've adopted that statutory scheme, and we have transposed it into this situation.

It is important that survivors not be forced to undergo more legal proceedings than necessary in order to obtain the redress they deserve. Compensation is fundamental to healing. Therapy is expensive. They have lost income. There is no reason why they shouldn't have all of the issues settled before one adjudicative body.

Don't force survivors to go to a civil court, perhaps at the expense of not having enough energy to go through the discipline proceeding as well. Remember, the civil courts cannot take away the licence of that physician; only the discipline body can. The way the legislation is currently drafted, the only way she can get her compensation is by going to those civil courts.

We do not have an objection to the college seeking reimbursement or restitution to the fund from the respondent in appropriate circumstances, for example, as a precondition to re-entry into the profession. We believe there are certain strategies which can be adopted which will reduce an undue financial burden on the colleges. But if someone is going to suffer here, it shouldn't be the survivors. They are the innocent parties here.

We also advocate for a provision which would allow for an interim award. This is an award pending the resolution of a complaint. The interim award would be solely for the purpose of providing funding for counselling. Again, the Compensation for Victims of Crime Act has that procedure, and in cases of sexual abuse, interim awards are often granted in order to allow the survivor to start her healing process sooner than later. It has the added benefit of having a survivor who is as strong as possible by the time she gets to the hearing. It is in everyone's best interest that we have a survivor who has the strength and the support to give proper and fair testimony. We have again provided draft legislation at page 18 of our brief.

On the note of professional misconduct versus incompetence, currently sexual abuse results in a finding only of professional misconduct. It is our position that they should also be found to be incompetent by the definition of incompetency itself. It involves a lack of judgement, an inability to discharge one's office or duty vis-à-vis patients. If they have violated the trust relationship in this kind of context, they are also unable to preserve the trust relationship with other patients.

This is not just a matter of tags or labels. There are two practical ramifications of calling this incompetence.

The first is that when the respondent files a notice of appeal, if he does, currently that notice of appeal would automatically stay or suspend the operation of the disciplinary award, which means that professional is practising for probably another two years before the appeal is resolved. That obviously places not only other patients but the colleges at risk in the event that there are further acts of sexual abuse, because there is prior knowledge.

The second practical effect is the possibility of attracting insurance coverage for compensation claims. It is arguable that medical malpractice insurance policies will respond to compensation claims. By calling it incompetence, we can't guarantee insurance coverage, because it hasn't been finally settled before the courts, but it gives survivors and the colleges frankly an opportunity to get that declaration from the courts. That obviously would share the financial burden of the healing process of survivors more adequately across society.

Finally, the definition of the term "patient": "Patient" is not defined in the bill. The common connotation to that term, I suggest, would be that the abuse has to take place during a then current doctor-patient relationship. This does not deal with situations where a professional, artificially perhaps, terminates the relationship in order to then engage in what is ultimately sexually exploitative conduct.

It is our recommendation that the term "patient" be defined to include former patients where the relationship involved an element of trust, was recently terminated and the subsequent sexual relationship was ultimately harmful to the wellbeing of the patient.

2220

In conclusion, the Out of Patients Advocacy Network does applaud the government of Ontario for introducing

legislation in response to the several excellent recommendations made in the final report of the Task Force on Sexual Abuse of Patients. Our recommendations are designed to strengthen and clarify the draft legislation. They should not be taken as an expression of discontent with the bill. To the contrary, we urge the government to pass the bill as quickly as possible.

Until the procedural and substantive safeguards accorded to patients represented by Bill 100 are enacted, many survivors will not come forward with legitimate complaints of abuse. All the while, the public trust in the health care professional community will continue to be undermined and will ultimately lose its effectiveness. The societal interest in having a health care professional community which is worthy of the trust vested in it is a paramount and urgent goal which deserves the immediate attention of all members of provincial Parliament.

**The Vice-Chair:** Thank you. During the presentation there were two members who indicated they had questions.

**Mrs Haslam:** I know it's late, and I know a lot of us are in the situation where we do want to go, but this is very important. This committee has extended time to hear people come in and talk about it. We're very pleased we could do that, so I apologize for the lateness of the hour but I think it's a very important topic.

I have two things. First, in number 9 on page 3 in your recommendations, or your draft legislation, you talk about the terms "patient" and "former patient," but you don't talk about time lines.

**Ms Vella:** We tried to deal with that by saying, "includes a former patient where the professional relationship involved an element of trust and is recently terminated." You can't put a fixed time period. It would be up to the adjudicator to determine when the influence which had been derived previously through the trust relation had terminated. I don't think we can get any more specific than that. But let's remember that if the sexual relationship was ultimately detrimental to that patient's wellbeing, then this fiduciary should still be responsible for that misconduct.

**Mrs Haslam:** As a lawyer, though, I'm concerned, because on the other side of this argument is the fact that I have gone to the dentist. I go once a year, twice a year, and I no longer go to that dentist, I've changed dentists, and I meet that dentist at a social function in a social capacity. We ultimately have a relationship that is broken off.

Therefore I am concerned, and would I have a comeback on him saying, "This is my dentist and therefore I felt there was"—or it was my physician, for a short time. I think as a lawyer I question being ambiguous in the time lines and whether the time lines and not being precise in them would be detrimental to the case in the long run.

**Ms Vella:** With respect, there is certainly precedent, lots of case law jurisprudence to define ambiguous terms such as "recent." I think it would be incumbent upon the college's prosecuting counsel to bring that case law to the attention of the tribunal, to show where the case law

would be relevant and to make that determination at that time.

**Mrs Haslam:** Then that answers my question. Thank you.

I had one more question—and I apologize again for this. You say that sexual abuse and sexual harassment should be included as incompetence. I listened very, very carefully and I still must ask for clarification on that. I really didn't understand totally why they should be included as incompetence.

**Ms Vella:** Incompetence is defined as being unable to exercise appropriate judgement in the context of your professional duties. Sexually abusive conduct represents the ultimate in the violation of that trust and therefore the ultimate, in my submission, in error of judgement, if you will. If we look at the Hryciuk inquiry, in fact the judge was found to be incapacitated, unable to discharge his duties, because he showed bad judgement—bad judgement in his behaviour towards his colleagues.

**Mrs Haslam:** That clarifies it for me and I appreciate that.

**Mrs O'Neill:** Ms Vella, I wanted to go on the same point, because I'm not sure you have access or have seen the suggested amendments of the government.

**Ms Vella:** Probably I have. There have been very many of them.

**Mrs O'Neill:** It's just that the "incompetent" and "incapacitated" are now being removed from section 85.1(1) and being reworked into, I suppose, a different kind of definition. How do you feel about that? It doesn't seem that what you're suggesting ties in with the way the government's now presenting.

**Ms Vella:** Providing that the reworking of the term addresses the same type of lack of judgement, the same notion of malpractice or negligence or incompetence, I don't think I have a difficulty with a wording change. We would simply adopt whatever the rewording of that legislation is, as long as it does involve the sanction for incompetence fundamentally.

**Mrs O'Neill:** I don't know whether legal counsel would like to comment on this. My judgement would be that it doesn't, but I am not a lawyer. Maybe one lawyer should speak to the other about this.

**Ms Vella:** We'll be here all night, won't we?

**Mr Wessenger:** If legal counsel cares to respond.

**Mr Owens:** Is this billable hours, though? That's the question.

**Ms Vella:** No.

**Ms Christine Henderson:** I was just intrigued by your last comment, that as long as the sanction is similar. Is what you're really getting at the sanction; namely, for example, the procedural right to a stay of proceedings on an appeal?

**Ms Vella:** And the characterization of the conduct as being incompetence for insurance coverage purposes, because right now, arguably at least, the insurance policy doesn't cover damages arising from professional misconduct, and that's because that terminology isn't generally reflected in the standard insurance policies. It's an open



question before the courts, but if we want to have a better chance of making our argument, we need to have the characterization of this conduct not only as professional misconduct but also as incompetence.

**Mrs Haslam:** As a clarification then, what you're asking for in the legislation is wording to help get insurance coverage for the compensation.

**Ms Vella:** I'm saying that would be a practical application, I think a positive consequence.

**Mr Owens:** What you're hoping is to force the punitive judgement on the issue by legislating—

**Ms Vella:** No, I don't think that will do it, because it will still be up to a court to decide whether or not the policy was intended to cover that kind of harm, but it has not been decided yet. What we're saying is: Don't stop us from making the argument. Allow us to make the argument. But this is not all about insurance coverage. That is just one of the tangible benefits that might be derived from the suggestion. We're also concerned about the stay provision. It's very important.

**Mrs Cunningham:** Just a question: Some of the witnesses, although they were in favour of the legislation and they want to move quickly, do have some very real concerns about the cumbersomeness—not a very good word—how cumbersome the bill may be, especially with regard to some of the mandatory reporting aspects. But I think they would feel very comfortable if we went with it, even though as this point they're disagreeing, if there were a sunset clause so we can take a look down the road at how it worked. It was presented as a solution earlier. Would you agree with that?

**Ms Vella:** I think that probably is wise. The concept and notion of sexual abuse and sexual exploitation and sexual harassment is evolving. What we see as sexual harassment today we sure didn't 20 years ago, at least not before the courts. So I think you have to have that review in order to adjust to what the present—the then current—understanding of that kind of conduct is.

**Mrs Cunningham:** I was just sitting and listening to you tonight and thought how refreshing it is in this whole process and how fortunate we are to have your level of expertise. I really think we witnessed, on more than one occasion tonight but especially with yourself, a level of expertise that isn't in my experience, doesn't happen often, and I wanted to thank you for that.

**Ms Vella:** Thank you.

**Mrs Haslam:** Hear, hear. I think that's why we took extra time.

**Mr Wessinger:** It should be clarified that presently under the Regulated Health Professions Act the advisory

council must review all the provisions of the Regulated Health Professions Act, including these with respect to sexual abuse, within five years. So it already exists, a review within the five-year period.

**Mr Owens:** Just a quick question which may elicit probably a longer answer in terms of the advocacy needs for victims: This is something that I've been quite concerned about since starting the RHPA process approximately two years ago, since we've been on this, but I don't yet have a sense. I'd be looking for recommendations from a person who is currently working with victims in the civil litigation area, as I understood your practice. Could you comment on that, on some of the issues you see needing to be addressed?

**Ms Vella:** Certainly. In fact, we do address it in our brief. In order to make the right to mandatory standing for complainants a right that has any real meaning, survivors must have independent legal representation. The respondent has legal representation, the college has independent legal representation, and the complainant has to be on the same playing field, if you will, in order to have an effective voice.

It is certainly our position that this legal representation should be paid by the college. The college can recover those costs as against the respondent if it sees fit. In any event, it should not be the survivor who goes unrepresented.

It will require a specific amendment to the legislation to vest in the panel the ability to award costs. That would be another way to go about it, that the respondent be made to directly pay the costs of the legal representation of the complainant, assuming there is a finding of liability.

Those are two ways that you could go about facilitating the funding of representation.

**Mr Owens:** In terms of representation, if one should choose not to have legal representation but perhaps an advocate of a different type, how would you encompass that into the language without restricting the kind of advocacy?

**Ms Vella:** Well asked. I don't think you'd use the phrase "legal costs"; you would use the term "costs." So the cost of having representation would be funded. I think you would get around it that way. You wouldn't call it "legal costs."

**The Vice-Chair:** Thank you for your presentation. Is there anything else before the committee? If not, the committee stands adjourned, I understand, until 3:30, Monday, December 6. Thank you for your attendance.

The committee adjourned at 2233.



## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York North/-Nord L)

**\*Acting Chair / Présidente suppléante:** O'Neill, Yvonne (Ottawa-Rideau L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

**\*Cunningham, Dianne** (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*Owens, Stephen** (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Akande, Zanana L. (St Andrew-St Patrick ND) for Mr O'Connor

Haack, Christel (St Catharines-Brock ND) for Ms Carter

Haslam, Karen (Perth ND) for Mr Hope

Mathyssen, Irene (Middlesex ND) for Mr O'Connor

Sullivan, Barbara (Halton Centre L) for Mr McGuinty

Wessinger, Paul (Simcoe Centre ND) for Mr Martin

White, Drummond (Durham Centre ND) for Mr Rizzo

### **Also taking part / Autres participants et participantes:**

Jackson, Cameron (Burlington South/-Sud PC)

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Henderson, Christine, legal counsel

Wessinger, Paul, parliamentary assistant to the minister

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Gardner, Dr Bob, assistant director, Legislative Research Service

Swift, Susan, research officer, Legislative Research Service

## CONTENTS

Monday 29 November 1993

<b>Regulated Health Professions Amendment Act, 1993, Bill 100, <i>Mrs Grier</i> / <b>Loi de 1993 modifiant la Loi sur les professions de la santé réglementées, projet de loi 100, <i>M<sup>me</sup> Grier</i></b></b>	S-601
Toronto Psychoanalytic Society	S-601
Dr Paul Finnegan, president	
Dr Ray Freebury, member; director, Toronto Institute of Psychoanalysis	
Dr Patricia White, member	
Royal College of Dental Surgeons of Ontario	S-604
Dr Richard Beyers, president	
Dr Minna Stein, deputy registrar	
Solette Gelberg, public representative, college council	
Ontario Board of Examiners in Psychology	S-606
Dr Catherine Yarrow, acting registrar	
David Lumsden, public representative and co-chair, client relations committee	
Sylvia Bradley	S-608
Registered Nurses' Association of Ontario	S-612
Dr Ruth Gallop, member	
Ontario Hospital Association	S-614
Peter Harris, chair of the board	
Patients' Rights Association	S-616
Peggy Pasternak, member	
Mary Margaret Steckle, executive director	
Josie MacPherson	S-617
Metro Action Committee on Violence Against Women	S-620
Susan McCrae Vander Voet, executive director	
Susanna Klassen	S-621
Sylvia de Persis	S-623
Joyce Emerson	S-625
Irene Crews	S-628
Ontario Dental Hygienists' Association	S-630
Ontario Association of Medical Radiation Technologists	S-630
Robin Hesler, executive director	
National Association of Women and the Law	S-633
Nicole Tellier, member	
Ontario Association of Professional Social Workers	S-636
Barbara Chisholm, spokesperson	
Women's Health in Women's Hands	S-639
Vuyisuva Keyi, health promotion coordinator	
Respiratory Therapy Society of Ontario	S-642
Sean Kenny, president-elect	
John Bell, past president	
Transitional Council for the College of Dental Hygienists of Ontario	S-644
Linda Strevens, registrar	
Jane Rogers, chair, working group on Bill 100	
Survivors of Medical Abuse	S-646
Josie MacPherson, facilitator	
Sharon Danley, cofacilitator	
Velma Demerson, member	
Out of Patients Advocacy Network	S-648
Susan Vella, legal counsel	

*Continued overleaf*

C1201  
Xc 12  
-577



S-26

S-26

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 6 December 1993

# Journal des débats (Hansard)

Lundi 6 décembre 1993

## Standing committee on social development



## Comité permanent des affaires sociales

Regulated Health Professions  
Amendment Act, 1993

Loi de 1993 modifiant la Loi  
sur les professions de la santé

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 6 December 1993

The committee met at 1539 in room 151.

REGULATED HEALTH PROFESSIONS  
AMENDMENT ACT, 1993

LOI DE 1993

MODIFIANT LA LOI SUR LES PROFESSIONS  
DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 100, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 100, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

**The Chair (Mr Charles Beer):** The committee is called to order to consider Bill 100, An Act to amend the Regulated Health Professions Act.

TASK FORCE ON SEXUAL ABUSE OF PATIENTS

**The Chair:** Our first witness today is the independent Task Force on Sexual Abuse of Patients in Ontario. If you would be good enough to come forward and introduce yourselves for Hansard and then please go ahead.

**Ms Marilou McPhedran:** Mr Chair and members of the committee, my name is Marilou McPhedran and I was honoured to be commissioned by the College of Physicians and Surgeons of Ontario in 1991 to chair the independent Task Force on Sexual Abuse of Patients by doctors.

I am joined today by a colleague of mine on the task force, Pat Marshall, who in many ways led the examination of the issue of sexual abuse by professionals some 10 years ago in her capacity as executive director of Metrac, the Metro Action Committee on Public Violence Against Women and Children.

I asked Pat to join me here today because frankly, as I was preparing my remarks, although you don't have written remarks because I only prepare them in my head, I realized that it might be very helpful at this juncture to ask Pat to be here not only as a colleague from the task force but also as the person who just completed a grueling national panel on violence and to perhaps put this bill in a larger context for all of us. So if I may, I would like to ask Pat to say a few words to you.

**Ms Pat Marshall:** This is a very special opportunity to be here now on this our national day of remembrance for women murdered in Montreal and for all the women in Canada who have been killed and injured by violence. It feels very appropriate. First we mourn, then we work for change.

I'm here today after a terrible journey across this country with a very strong message that the most valuable work that can be done now but also the hardest work and the most necessary work is to dismantle the tolerance of the violence that is so pervasive and so with us every day and in every part of this country and this province.

There is no doubt that tolerance is the glue that's holding the violence together, and the violence of sexual abuse that involves a breach of trust is still and yet the most invisible kind of violence and violation. The toler-

ance of that sexual abuse involving the breach of trust is the hardest to see. It is that challenge that you share with the rest of us who are doing this work now to try to work for this so necessary change.

Bill 100 is historic proposed legislation. It's an important example of the real kind of change that is needed, because it's not cosmetic. It is not a total answer to a huge problem, but it is an important start. You are now doing the most valuable work that governments can do. As governments confer powers on others, they can and must set the appropriate standards of responsibility that will do all to ensure that public safety is upheld in the most effective ways possible.

You will know by now that the history of the tolerance of abuse in the health professions and the abuse itself is not a pretty picture. It is very entrenched; it cannot be changed and will not be changed easily. Abuse of power and trust both at the individual level but also at the institutional level, which many of us have tried to name for over a decade, as Marilou said, has been hard to recognize. It's been hard for us as a society to recognize it. Those institutions we were taught to trust have failed us so badly through their own disregard and tolerance of abuse by their members.

From me and the work, I bring you my own sense that the greatest tragedy of all, besides the violence itself, is that almost all violence that I have seen is preventable. Zero tolerance, and the principle of zero tolerance when appropriately implemented, will prevent violence and the injuries it causes. It's why the College of Physicians and Surgeons' independent task force that Marilou chaired and I sat on and the Canadian Panel on Violence Against Women both concluded that zero tolerance was the only basis. For the panel I must say that we made it the foundation for the largest national action plan that's ever been put together, formulated to try to end violence.

I have to also tell you there was much soul-searching. It was not easy to come to, and part of it was because of the uses that zero tolerance has had before. There have been such reactive, limited uses, what I would suggest are the Reaganesque uses of the term that it in fact has been very confusing. But we felt that the antidote to that was to spell out, as we did in the final report, in considerable detail what zero tolerance would mean in action plans for all sectors in society.

I would say that the media have not served Canadians well in that we have not seen those details well reported publicly; they have not been reported publicly and the report is still admittedly very difficult to get. I was trying to get copies for you today. But there are enough details. It saddens me to see when zero tolerance is a term that becomes rhetoric and is used carelessly and thoughtlessly as a blanket to be thrown over a number of actions when zero tolerance can be so useful when it is the basis of the recognition of what is wrong now, the tolerance that is in place now, the status quo that is so unacceptable and the

cavernous vacuum between what we have now in health professions and what is needed to be in place to bring public safety and safety for patients to an appropriate level.

If I may just mention a couple of the principles of zero tolerance from the report that are relevant to the discussion of Bill 100, those with a responsibility for public safety have an obligation to take the most comprehensive and effective action possible to prevent violence from happening. For government legislators such as yourselves, the legislation that you create is obviously one way.

I would also urge you to recognize that legislation is not going to be enough. You will know that. One of the things you could do that would make the implementation of the legislation that you choose so effective would be to do everything in your power to ensure that those health professions that are self-regulating implement as soon as possible zero tolerance action plans that will ensure that those who have the responsibility for upholding public safety, with the tremendous power that you confer on self-regulators, will do so in the most effective manner.

In the report of the national action plan we have in place the hiring responsibility, the kinds of criteria used for appointments, for training, the kind of policy formulation that for one thing, and I know this is something that has come up during your hearings, shows the inextricable link between violence and equality. We can't keep separating these out and saying this month we're going to deal with abuse in this form but we're not going to look at the other equality issues. It was a difficult decision to come to but at this point we can't separate those out. We must look in a more comprehensive way. These action plans do it.

There is an accountability and there are mechanisms for accountability that must be in place in those self-regulating bodies. That would make such a difference. Another thing that would have made such a difference for these hearings that you've just gone through now, I was thinking last night about how different this process might have been for you if the self-regulating bodies that are in place now had all fully implemented zero tolerance in this priority commitment to safety in that way.

We must, with zero tolerance, dismantle the policies, practices and programs that are not working, and there are many in place by health professionals that are dangerous to women's health, as you've been told. We must differentiate the commitment to zero tolerance from the lipservice use of zero tolerance, and that's difficult because nobody directly says that they support violence or an act of violence or abuse directly. But the smallest changes are now being labelled as zero tolerance, and that is not adequately going to support the safety of patients.

We can discuss that a little bit more. Sometimes it's because any change is magnified for those who are very supportive and who benefit from the status quo and sometimes it is that they don't understand. Something I hope you understand is that with the kind of great fiscal pressure you are under, if we can prevent violence, and the kind of legislation that you're now discussing will help in that prevention, the economic benefits of prevent-

ing violence from happening in the first place are incredible. We're very naïve about that and the panel report also speaks to that.

#### 1550

Because governments and institutions have a primary responsibility to demonstrate leadership as a principle of zero tolerance, you may be confused, as the rest of us have been, by looking to the traditional sources of leadership, and one of the main ones has been the courts. It is where we look so often for leadership in this area. This has not been forthcoming from the courts because of the limited understanding of sexual abuse involving breach of trust.

When I was at Metrac I did studies of this. Sadly, although there have been glimmers of change, there has not been enough. In fact the courts are often used, as you know, as a standard for activity for self-regulation, and to the extent to which they don't understand breach of trust in sexual abuse, patient safety has been jeopardized. The lack of understanding of rehabilitation and the lack of understanding of the related issues are also a major problem that has implications in the legislation that Marilou is going to talk about.

I just want to end by saying that with the legal vacuum that has been created by the lack of leadership in the courts, this has some incredible implications not only in terms of the lack of understanding of how the traditions in the legal system are dangerous for women in a number of ways that we can talk about also, but also it puts an increased responsibility on you as lawmakers to bring out legislation that is clear and really does conform with zero tolerance, as I believe this government and the legislative drafters have understood in the drafting of Bill 100.

We can talk about the details, and Marilou will comment on those, but this is a most critical passage, and that is my major message today, although I'd like to discuss some of the other details of zero tolerance in a few minutes.

**Ms McPhedran:** Mr Chair, let me just do a time check with you. Go ahead?

There are a number of people around this table with us today who have spent a good deal of time and energy on this issue already. Many of you have had meetings with myself and colleagues from the task force as well as representatives from a broad range of perspectives on this issue.

I won't even begin to try to summarize what you folks have been hearing over the past intense days. However, I do want to draw a couple of observations. As someone who spent a year of my life immersed in the study of this issue and who actually ended up donating about \$50,000 of billable hours in order to complete the task force, I have more than a small amount of professional commitment to this as well as a strong personal concern.

One of my observations is that I'm not sure there has been a sufficient development of the understanding that we are talking most particularly about abusers, but perhaps even more important, we are talking about enablers. We are talking about the way in which the systems that we have come to rely on in our daily lives



and that we want to trust and rely on in fact enable ongoing abuse. You know that saying from the 1960s, if you're not part of the solution, you're part of the problem. The flip on that for me is that there are many ways in which we can wittingly and unwittingly enable abuse.

I want to invite you, as lawmakers, to not slide into the enabling category, to take courageously the role that you clearly have in law to lead on this, to set the standards on this. I think back to 1991 when we released the preliminary report to a storm of protest, particularly led by the Ontario Medical Association, and the way in which the choices were made by professional organizations to make their members more afraid, to not try to reduce their confusion. In the midst of that we had a private member's bill from Ernie Eves, with considerable work that was done, presented, that supported the task force's preliminary report at a time when it was not a very politically popular thing to do.

There has already been significant leadership from all three parties represented in this room and I urge you to hold on to that standard that you've already established. In some ways I want to suggest to you that it should be relatively easy because, frankly, I'm not overly impressed with this bill. The key legal changes that were recommended by the task force have simply not been realized in this bill.

If you're worried about being radical, don't worry any longer. It's okay. You are working with a piece of draft legislation that is in my opinion the minimum and the most important thing about it is that it finally names sexual abuse, and just for that, I'm here today to urge you to pass Bill 100.

Most of the government's proposed amendments further weaken the bill. I think there has been some phenomenally successful lobbying by some very rich and powerful organizations that have heavily influenced legal counsel and the drafters of this bill. I salute them in their astute use of the democratic process in bringing about such a positive result in favour of their professional organizations.

I'm saddened by the simple fact that there is a bit of a professional shell game that has been played here. I reviewed a number of the names of presenters and I noticed that you have seen, wearing a number of different caps, a number of the same people coming back to you over and over again to reinforce their message. I invite you to ask yourselves what is the difference in resources, what is the fire-power that's being directed here and to what extent will you as lawmakers be swayed by the greater resources that the professional groups have been able to bring to bear on this?

I also want to observe—and this is something that Pat particularly wasn't too clear I should do, but I have to call it the way I see it. The Canadian Bar Association of Ontario has been depicted very often as an objective, highly professional organization. I think it is a highly professional organization, but I invite you to consider the possibility on this issue that the presenters who have come to you, given their livelihood on which they rely representing health professionals, have probably not given you what would be a more objective point of view.

I want to also invite you to understand that up until today the patients and the advocates working for patients had no money to work with. Their funding stopped over a month ago and the government did not reactivate that funding until today. Please think about the difference in the numbers of people who have come to you and lobbied you and lobbied people who work for this government. Understand that you have opportunity to take a leadership role on this legislation and to hold to the positions you have developed previously.

1600

It's too late to improve Bill 100 to the degree that I believe it has to be improved. The task force recommendations around corroboration, around similar-fact evidence, around party status, even intervenor status, which ended up being the compromise position of the task force, none of them is in this bill—none of them.

You have heard from a number of presenters that somehow this process has to be considered penal in nature and criminal in nature, and the charter has been invoked to you over and over again without any substantive legal analysis to tell you why the ghost of the charter is being invoked.

I want to take a moment just to raise a couple of general points about the charter because that seems to be the call to arms that is being used by lawyers and others representing the professional groups. The position that seems to have been taken in a number of different ways before you from the various briefs I've had a chance to review is that you are somehow, by enacting Bill 100, and by even considering some of these further weakening amendments the government has proposed, going to be infringing on the charter rights of professionals.

We simply don't know the answer to that until the courts have to deal with it. You have seen for yourselves how time after time the courts have identified so strongly with the professionals, so strongly with doctor after doctor in their judgments, and they don't even mention the damage to the patients in their decisions when they soften what the disciplinary tribunals for the College of Physicians and Surgeons have done in a number of cases.

So, the charter: Well, as it happens, the charter doesn't apply at the present time to disciplinary proceedings before the College of Physicians and Surgeons or other health profession disciplinary bodies. It doesn't apply. That has yet to happen in law.

However, because, with primarily the leadership of the OMA, there was so much concern and at times even hysteria among members of the profession as to their charter rights, we addressed that issue through independent legal research. A couple of the points may be helpful for you because I know there have been very serious attempts to spook you about what the charter might do to individual professional rights.

When you're talking about freedom of association under section 2 of the charter, remember that, as lawmakers, the case law already in place, all the way to the Supreme Court of Canada, gives you a responsibility and a discretion to look at infringing rights where those rights can be "demonstrably justified" in our democratic

society, particularly where those rights relate to vulnerable groups. I think we would be in agreement among us today that patients count as a vulnerable group.

The other thing about the case law so far is that, where lawmakers have drawn clear lines, judges have shown a distinct tendency to respect that authority. That is your job, and to do it well will mean drawing clear lines so that judges can be guided and, frankly, so that you can help them move into the next millennium with some understanding of what happens to patients when they are abused and their trust is violated.

In regard to concerns about the principles of fundamental justice as it relates to anonymous reporting, as it relates to mandatory reporting, let me remind you that under the Health Disciplines Act and under the RHPA there will be no breach of confidentiality or knowing of names until there is an investigation. There will be no investigation unless the colleges have reasonable and probable grounds for believing that an act of misconduct may have taken place.

Under mandatory reporting, the concern is one of freedom of expression, including not being forced to express, ie, to mandatorily report on a colleague. If you refer to the existing law and the way in which this sort of requirement is tested, I think it is very interesting to ask ourselves the question: How is it that we have, in the most recent issue of the CPSO Members' Dialogue, reference made, without any concern or criticism whatsoever, about a doctor's obligation to report patients unfit to pilot aircraft, in addition to the doctor's obligation to report patients unfit to drive a car? How is it that the public interest is acceptably and adequately served by that profession when it relates to driving a car or piloting an aircraft, yet there is such enormous difficulty when it comes to reporting on abuse of patients?

One of the things that also really concerns me about some of the points that have been made to you around mandatory reporting is the way in which the question "Is this demonstrably justified in our democratic society?" has really not been addressed. The existing case law on this, which is the Slight decision in 1989, says that where you have an infringement and it can be demonstrably justified where it is protecting the interests of a vulnerable group, then that is something that is allowed by the charter.

This is pure speculation. I won't take any more of your time with it because, frankly, it isn't something that should spook you. You make your decisions as lawmakers. The charter at the present time is not applied, and if it's applied and it's tested, so be it. That's the system we live in. Those are the rules we follow. You will have the opportunity at a later date to clarify and strengthen the legislation consistent with any judicial interpretation, but please don't let that stop you from doing what is the absolute minimum at this point in time.

I wanted to make a couple of quick comments about Bill 100 itself. If you have to fiddle with this bill, please stay as much as you can with what's already been tabled. Forget about most of the government amendments. Somehow, the drafters and whoever put this package together for you have been very heavily influenced to

favour professions even more than they're already favoured. If you are doing this process here as a way of trying to level the playing field, which is an image that's been used over and over with you, then please consider the fact that there needs to be at least what is in the legislation that went through second reading.

For example, in the definition of "sexual abuse," what we heard at the task force was the doctors who took the time to come to the task force saying to us very clearly: "We want to be forced to report. Make it clear. Give us the details. If it's part of our duty as opposed to a guideline, then we will act on it." The time has come for the lawmakers of this province to make it much clearer and easier for health professionals to follow through on their duty to their patients.

If you look at the section that deals with intervenor status and parties, section 41, make one little change. Change "may" to "shall." At least do that. Bill 100, as it passed second reading, has in my opinion given you what is a step back from the existing law on the issue of parties and intervenors. As it stands in the legislation that has governed the College of Physicians and Surgeons, they already have the option of naming parties in an incapacity hearing. How is it that this isn't considered of sufficient concern and value in the public interest that that option would be left open? At least give intervenor status and don't in any way limit or preclude the option of a tribunal to give party status. The Law Society of Upper Canada has done it. There's no reason why health professional disciplinary bodies can't also do it. So at least make that one word change.

I'm greatly concerned given the number of decisions, and to give one concrete example, the Singh decision—you may remember the doctor in Sarnia who abused a number of patients and mothers of patients. A recent decision of the College of Physicians and Surgeons of Ontario didn't even mention rehabilitation of Dr Singh. The government notes on Bill 100 talk about actually "de-emphasizing" rehabilitation, taking away from the regulations a greater obligation on the part of colleges to look at rehabilitation seriously.

You will recall that the task force took the position that nowhere in North America could we find a so-called expert on rehabilitation who would put his or her reputation on the line and say, "I can rehabilitate a sex offender." Let's be realistic about the state of the art here. It ain't there. So to de-emphasize rehabilitation when we already know that it is perhaps mythology is very dangerous and not in the public interest.

#### 1610

I'm going to wrap up by asking you to remember that we'll always have another crack at this. This is the first step. The way in which change occurs in our society is through incremental first steps. The kind of backlash and concern that has been expressed to you over and over again by the spin doctors and the panoply of paid representatives from health professional groups—of course it's important to acknowledge that and to acknowledge their fears. Let me suggest to you that is primarily what they are—fears—and that they are not the basis on which lawmakers need to act in the public interest. Thank you very much.



**The Chair:** Thank you both for your presentation. We'll move right to questions.

**Mr Jim Wilson (Simcoe West):** Marilou and Pat, as always, I think you gave an excellent presentation. There are some points that I would like to perhaps debate and explore further with you, but I know we're limited in our time.

Marilou, I'm glad your parting comment was something like, "We'll always have another crack at it." I think the history on this issue shows that it's taken a long time to even get to this bill, and our interest has been to try to get the bill right. You said earlier in your comments that you thought it—I think you almost went so far as to say it was fundamentally flawed in some areas, but that might be a bit strong.

But in the interests of getting it right—and we have closure, as you know; this has to be done by 5 o'clock tomorrow. We haven't heard, as you said, from a number of survivors. We know and we recognize the faces of the repeat professionals who have appeared under different titles, but that's part of the process. That happens with all legislation. So you'll know, for the record, we've seen some repeat survivors too. So it happens as part of the process.

I do want to ask you about one specific area, and that's mandatory reporting. It's no secret, because I've said it on the public record for the past few days, that I have some sympathy for patients who are undergoing psychotherapy. The question I have is, if a patient absolutely does not want his or her physician or psychotherapist or psychiatrist to report an incident of sexual abuse with a health care provider, does the patient not have rights to direct his or her own physician in that regard?

**Ms McPhedran:** I think that in some ways we might be trapped by the hypothetical. In the well over 100 interviews that we did, this is one of the discussions that we had with real, live patients who'd lived through this situation, as opposed to hypothetical patients who have been conjured for you here. What was clearly articulated to us was the numbers of times that they did want their treating professional to report, and the professional didn't do it.

In the cases where the patients talked about their hesitation, what they described to us was an intelligence and a decision on their part that they would not give the information. You can do therapeutic work without naming and identifying the professional who has abused you. Where there is clear information given in that therapeutic relationship so that the patient understands from the onset that if sufficient information is given, then the treating professional has no option, the patients are in a position to stay in charge. They don't have to give the identifying information in order to be able to work on the healing process. When they're ready, they can give the identifying information, and that kicks in the mandatory reporting.

**Mr Jim Wilson:** Except that we've had testimony that it's not clear-cut when the patient gets to that point of ready to report. You mentioned, which you meant, I presume, as a parallel to this, the pilot's licence requirement. Dealing with psychotherapy, it's not clear during

that process. At what point, then, does the treating practitioner have to stop and say, "You can't tell me any more about your life because I may have to report you"? How do you deal with that?

**Ms McPhedran:** That shouldn't be difficult if at the onset of the therapy and at appropriate points in the therapy, I trust in the intelligence of treating professionals to be able to say: "Let me remind you that I am under a legal obligation to report if you identify your abuser. Let me remind you. The choice is yours; the power is yours. Here's the information for you to work with that and make your decision." Truly I don't think it's that complicated.

**Ms Marshall:** It has been implied, if I may add, that as soon as the report goes in about the name of the abusing health practitioner, there is some sense that all of a sudden the reluctant patient is ending up at a discipline hearing, which is not the case. It is only with the agreement of a complainant that other processes can go into place. But the documentation of patterns of behaviour can then start in a very different way without activating those other processes that then go on only with the agreement of a complainant.

**Mrs Karen Haslam (Perth):** I really appreciate that information about hypothetical patients, because we have had cases where they've come with hypothetical cases. I appreciate the comments you've both given us and it's been very, very clear. I do want to say, though, in defence of perhaps the Chair and this committee, I think you underestimate the people on this committee.

We have had a number of people come, and you're right; we are well aware that they are physicians with different hats in different organizations—

**Ms McPhedran:** And lawyers.

**Mrs Haslam:** —but I think you've underestimated all of us on this committee if you think we are swayed by the title "lawyer" or "doctor" or the fact that there are three versus one in those chairs. So I'm just going to pass that on for your edification.

I wanted to talk a bit about the mandatory reporting. Mr Wilson has effectively mentioned the psychotherapy involved. We've also had people come asking for exemptions in physical therapy in the massaging area. I wonder if you'd make a brief comment on that, and also—well, I'll let you answer that, because our time is limited.

**Ms McPhedran:** Let me actually respond to your edification point. If you get a chance to review my words, you will find that I didn't make any assumptions about your being swayed. What I did was bring to you my observations based on my review of the presentations to you. My hope and my expectation is that, being far more astute at this process than anybody else since it's your job and you do it every day, indeed you would not be swayed. However, I was disturbed and struck by the professional shell-game aspect of this, and I needed to put it on the record. I trust that it was in no way new information for you.

Let me respond in a very personal way to the hypothetical around massage. We made a general statement in the task force report that I think applies to this specific



situation. The general statement was that patients know the difference. Let me give you a personal illustration of this.

When I first moved to Toronto 20 years ago and I was part of the early 1970s kind of hippy-dippy stuff, I became enamoured with the concept of massage therapy. I grew up in Neepawa, Manitoba. Believe me, there were no massage therapists there. I was treated by a qualified, licensed male massage therapist who was subsequently delicensed for having sex with his patients. I knew the difference. I knew when it was time to confront this man and to leave the practice. It was obviously a pattern of behaviour that was repeated over and over again, particularly with young women patients, and it was ultimately what cost him his licence and the right to practise. It took years before patients who had been damaged by this got it together and were able to make the report.

I think it comes down to that over and over again. Without in any way meaning to devalue your intelligence or anything like that, please let me ask you to ask yourselves a question which we asked ourselves on the task force over and over again: What is the underlying assumption in a number of these hypothetical situations? Is the underlying assumption that women patients—and we know the vast majority affected are women—are stupid, that women patients don't know the difference? A former colleague of ours on the task force, who subsequently represented the CPSO, actually said in public that women wouldn't know the difference between a doctor saying "You look well today" and "You look good today."

1620

Those kinds of hypothetical, trumped-up examples I think we can spot fairly quickly and know for what they are.

**Mrs Haslam:** Quickly then, would you agree to mandatory reporting on behaviour, and wording then also? You are in favour of that also?

**Ms McPhedran:** That was the task force recommendation. That is the one part of Bill 100 that has honoured the task force recommendation in full. Based on, as I said, the research that was done and the numbers of actual testimonies brought to us, we believe that it's a very important alarm bell just for colleges to be able to identify patterns. Even if it doesn't get beyond the anonymous reporting, that in itself is extremely important to allow colleges to do the job you, as lawmakers, have given them to do.

**Ms Marshall:** Could I add just one statement to that? Information on scope-of-practice issues might be very usefully circulated among the self-regulating professions. It's information that would be very useful to have if there are questions, and it's the kind of information that could be circulated very easily. One could check on that. But the information and the knowledge of sexual abuse is something that is very separate from the scope-of-practice issues so often. But to know what is in the scope of practice or what is entailed might be very useful.

**Mrs Barbara Sullivan (Halton Centre):** I wanted to ask you if you would comment on the Ministry of Health

proposals for amendments that would include a statement of impact from the patient or the patient's representative.

**Ms McPhedran:** There's no doubt—I think I can speak for both of us—that it's important information to give to the tribunal. It doesn't substitute for intervenor or party status. Please, absolutely don't let me stay on the record as in any way supporting this as a substitute; it is not a substitute.

**Ms Marshall:** And the one place where the charter does become very relevant is for you as lawmakers, if I may say. Section 15 of the charter, the right of all, including patients, to equal benefit and protection of the law, is a very important force, I believe, behind the legislative drafting. Marilou, with her significant help in developing that, would agree that's the place and the spirit that we hope will be very much with you in the work that you're doing.

**Ms McPhedran:** Frankly, if it gets challenged it'll be very helpful at the court stage.

**Mrs Sullivan:** It may well be.

**The Chair:** Thank you both very much for coming before the committee today. We appreciate it.

**Ms McPhedran:** Thank you, Mr Chair. We are essentially in support of Bill 100 because we're pragmatists.

**Ms Marshall:** And we wish you well tomorrow.

ELLEN BOYLE

**The Chair:** If I could then call our next witness, Ms Ellen Boyle, if she would be good enough to come forward. As she does so, Ms Boyle, we have a copy of your submission which has been circulated to members of the committee. So once you're settled, welcome and please go ahead.

**Ms Ellen Boyle:** My name is Ellen Boyle. I am a survivor of sexual assault by a well-respected Hamilton physician, the former Dr John Minich Sr. As a survivor of sexual abuse by a health care professional, I would like to strongly support Bill 100, specifically the mandatory reporting of all forms of sexual abuse. I would also like to express my concern that the needs of survivors upon disclosure are not being addressed in Bill 100. Funding for crisis intervention is essential.

If I had been asked four years ago if I had ever been sexually abused, in all honesty I would have answered no. Three years ago, denial worked well for me for as thoughts, feelings and memories appeared, I refused to acknowledge their meaning or existence.

On April 19, 1991, my world fell apart. My sense of who I was and what my world was all about came to an abrupt end. On this date, I was forced to acknowledge a horrific truth to myself. On this date, I struggled to speak the unspeakable. I struggled to speak the most difficult words I've ever spoken: I was sexually abused by my doctor.

Today's sceptics might declare this false memory syndrome. In this case, there was a guilty plea.

At the end of a radio talk show regarding the Task Force on Sexual Abuse of Patients, I was left with a flood of emotions, feelings and memories that I could not

longer contain. I felt emotionally out of control. It was the provision of a hotline number to call, the promise that someone would hear and the hope that I would be believed that gave me the strength to disclose.

Disclosure was just the beginning. I was not prepared for the sense of immobilizing terror that would become part of my life. I was not prepared for the abhorrence felt in touching others or being touched. I was not prepared for the feelings of defilement, humiliation, helplessness or guilt. I was not prepared for the additional memories that would rack my body in pain. I was not prepared for the terror that would invade my nights or the isolation of my days. I was not prepared for family members who would be unable to support me. I was not prepared to struggle within systems as an occurrence number, or within a community where I was, and I quote, "one more nut case coming out of the woodwork." I was not prepared to deal with the feelings that my whole being had been destroyed.

Prior to assaulting me 14 years ago, John Minich had been my family physician for a 12-year period. John Minich delivered my three children. I had no reason not to trust. John Minich's selection of me as a patient ripe for abuse was due to my own vulnerability at that point in my life.

Following the assault I discounted my experience, convinced myself that what happened couldn't have happened. He was a doctor; I was crazy. All memories were gone by the time I walked out the front door.

For the first time in my life, I became depressed, cause unknown. A year later, I left my marriage in what I now know was an anniversary reaction to John Minich's assault. I fled in fear, fear that something horrible was going to happen. I recall needing to feel safe, wanting peace of mind and desperately needing a long hot shower.

Survivors of sexual assault by health care professionals and health care professionals are all consumers of the health care system. Bill 100 is an attempt to provide protection for all vulnerable consumers. Life circumstances can leave each and every one of us vulnerable. It is when we are the most vulnerable that we need to reach out, confident that the utmost of professional care will be given to us. We need to trust that sexual abuse will not be our fate. As consumers, we need to work together to protect ourselves, our families and especially our children from opportunistic, sexually abusing professionals.

**Mandatory reporting:** The mandatory reporting of all behaviour or remarks of a sexual nature that are demeaning, seductive or exploitive is essential. Prevention of further abuse may begin here. For the abusing professional, such behaviour or remarks may be the testing ground or the beginning of a grooming process of escalating abuse. Arguments that this will be too time-consuming for professionals required to report are an indicator of the level of abuse that exists.

Sexually abusive behaviour or remarks by a health care professional indicates a total disregard for the consumer at a health care level and a total lack of respect for another person at a human level.

## 1630

What was permissible 20 years ago is unacceptable and intolerable today. It is the abuser who thrives on both secrecy and silence. It is the abuser who wants us to turn our heads and do nothing. All forms of sexual abuse need to be reported. There can be no exception. If we are not part of the solution—in attitude—we can become part of the problem.

**Funding:** As initially presented to the professional relations branch of the Ministry of Health on October 27, 1992, I have grave concerns that the issue of crisis intervention has not been addressed.

An immediate and caring response would facilitate the survivors' healing process rather than delay it. For survivors to be required to wait until a finding of guilt before any assistance is afforded them is both cruel and inhumane.

Survivors should not be left with only the crisis line of a sexual assault centre when their emotional pain is intolerable. Survivors should not be arriving at hospital emergency departments with panic attacks and abuse-related physical pain. Post-traumatic stress is costing the health care system millions of dollars for physical ailments which appear to have no cause. Crisis intervention is both preventive and cost-effective.

While immediate therapy of choice would be the ideal, I would like to suggest the following, which should not necessitate a finding of guilt:

(1) A crisis hotline operating 24 hours a day to deal specifically with the impact of abuse by health care professionals. Such a service could also be used to develop a needs assessment of survivors, and look at how these needs could be filled.

(2) Educational workshops to be set up and made available as needed for survivors and their families and/or support people. Topics could include the following: trauma—what it is, its effects; sexual abuse—short-term, long-term effects; post-traumatic stress; flashbacks—how to cope; panic attacks—symptoms, how to cope; coping strategies; system survival; self-care; discipline process, criminal process, criminal compensation and civil litigation.

Education and knowledge are the key to the restoration of personal power and control. Survivors need to know that their reactions and feelings are normal responses to an abnormal occurrence in their lives. Survivors often need to connect with other survivors of professional abuse. Survivors need resource material and coping skills.

Funding for the above would come from the compensation fund for survivors. Eligibility would be a lodged complaint with any college or association of regulated health professionals.

Educational workshops might also be considered under patient relations programs, an area where survivors, as a group, are noticeably absent regarding education and needs.

Survivors are patients with very specific needs, the greatest of which is the need to trust.

**Funding, maximum amount and period of eligibility:** Extenuating circumstances may necessitate the extension



of one or both of the above criteria. A process needs to be in place whereby neither the maximum amount nor the period of eligibility is fixed, and with reasonable grounds an extension may be applied for.

Sexual abuse by a health care professional is traumatizing. An immediate and caring response from colleges, associations and the community is essential for healing. With this support, we will heal well.

I would like to thank the Ministry of Health for the opportunity I've had to provide input into Bill 100. I thank all committee members for providing me with the opportunity to speak. Thank you for listening.

**The Chair:** Thank you very much for coming and sharing those thoughts with us, and in particular for the recommendations at the end. We appreciate it.

CHERYL BROWN

**The Chair:** If I could then call on our next witness, Miss Cheryl Brown. Welcome to the committee and please go ahead.

**Ms Cheryl Brown:** Members of the standing committee on social development, I am here today to share with you my experience of reporting a psychiatrist for sexual abuse to the College of Physicians and Surgeons of Ontario and to share my recommendations regarding Bill 100. I have copies of my presentation that I'll leave with you.

I laid a charge of sexual abuse against Henry Fenigstein in November 1991. This was termed "laying a complaint of professional misconduct due to sexual impropriety." This misconduct involved his having sexual intercourse with me while I was his patient and being treated by him for depression. The abuse took place over a period of six years during every individual therapy session.

I submitted a three-page statement to the CPSO on November 11, 1991. In the following months, six other women presented evidence of sexual abuse by Fenigstein to the college. As well, two former co-therapists of Fenigstein and a physician gave evidence of having been told by patients, clients or therapists of 19 other instances of sexual abuse perpetrated by him. Statements were taken from these nine witnesses and are on file at the college.

On January 2, 1992, Fenigstein verbally admitted guilt to the college on my complaint of sexual abuse and handed in his licence to practise. This is an action sometimes taken by physicians close to retirement to avoid further prosecution and public disclosure. In fact, I was told by the practicum coordinator at OISE, which has placed students at his group therapy practice for many years, that Fenigstein had telephoned her to state that he was retiring his licence due to poor health.

On March 25, 1992, he tendered a written admission of guilt to the college following frequent requests from the investigator to do so. Therapy groups continued to be run out of his office/home by therapists he had trained until April 1993, two weeks before the disciplinary hearing. He continued therefore to have access to patients. Three OISE students continued their training at his office until April 1992, four months following his admission of guilt of sexual abuse. The public, including

all of his former patients and those continuing to receive group therapy at his office, therefore remained unaware of the abusive practices of this doctor during the 16-month period between his admission of guilt and the disciplinary hearing.

At the disciplinary hearing, held May 17, 1993, an agreed statement of facts, agreed upon by the college and defence lawyers, and a victim impact statement I had written were read. The statement of facts described only the sexual abuse done to me. Although the college had evidence from nine other witnesses that Fenigstein was a multiple abuser, none of this was presented, giving the erroneous impression that his acts were solely against one person. The public was therefore not fully informed and thereby fully protected, and the panel made a finding of an inadequate penalty.

The panel made the decision at the hearing to accept Fenigstein's admission of incompetence and to revoke his licence in retrospect. They decided not to fine him. They therefore did nothing more than sustain his own admission of guilt and incompetence. In refusing to publicly censure his behaviour by imposing the maximum penalty, both revoking his licence and levying a fine, the panel sent a message to physicians that sexual abuse is not fully censured and is therefore to some extent excusable, and to survivors and the rest of the public, the message that zero tolerance is a myth and that the college does not in fact protect the public but protects its own.

I have subsequently been advised that there has never been a case where a physician has had his licence revoked and a fine imposed as well. Surely the maximum fine should be automatically imposed on any physician found guilty of sexual abuse.

1640

I learned only late in the process that all of the evidence was not going to be presented. I protested this and urged the college lawyers to go forward with a full hearing if that was necessary to present all of the evidence. I was told that the other evidence was being used to ensure a guilty plea and that they couldn't present it in the statement of facts because none of the other witnesses had made formal complaints.

I subsequently learned that at least two of the other witnesses had not been informed that they could lay complaints until late in the process, nor were they informed that unless they laid a complaint, their evidence of abuse would not be heard. They stated that they felt intimidated and upset by their contact with the college lawyers and decided not to proceed with an individual complaint if this was an indication of the process and what lay ahead. I referred to the other evidence in my impact statement, but was told this would not be accepted by defence counsel and had to delete this information.

I entered the process of charging Fenigstein with sexual abuse with the hope that the college had adopted the spirit of the recommendations put forth by the Task Force on Sexual Abuse of Patients. These recommendations would make the process a more equitable one and recognize the harm done to complainant-survivors by the abuse and then by the present process. I was prepared to work fully with the college.



My original hopes for the truth to be heard and justice to be done and be seen to be done changed to feelings of futility, despair and a sense of personal failure when I learned that the college would not be acting quickly on the guilty plea and then would not be presenting the full evidence of the abuse committed.

My repeated attempts to have input into the process were often greeted defensively, minimized, misconstrued or patronized. I became increasingly aware of my position of powerlessness. I had no rights in the process beyond that of being a witness. This had an increasingly debilitating and demoralizing effect as I came to realize that I had no recourse to make happen what needed to happen in this case. I saw an open-and-shut case against a multiple abuser being handled in a minimal, inadequate manner. The goal seemed to be expediency, not a full disclosure of the facts.

I believe that the problem underlying my experience with the college was my lack of status and therefore rights in the process. For this reason, I am recommending adoption of guaranteed full-party status for survivor-complainants. This, as you know, would give the right to make legal submissions, introduce evidence, cross-examine witnesses and appeal decisions. Full-party status would affect the whole process and make it more equitable. It would ensure that all interests involved in a case would be brought to the attention of panel members, resulting in better and more just decisions.

Full-party status would have given me a voice and input into the process. Because I had no status, I had no right to dispute or challenge the facts presented or omitted or of any real input into how the case would proceed. The Fenigstein case therefore became an example of a situation in which the penalty eventually imposed was not commensurate with the actual facts or harm done by him.

Arguments I have heard voiced by representatives of colleges and professional associations against full-party status seem to me to indicate a lack of trust in or recognition of the integrity of survivor-complainants—members of the public who have come forward to bring an abuser to justice. A concern was expressed that we might have a different agenda. My agenda was for the truth to be heard and justice to be done. What was theirs?

I also believe that survivor-complainants need to be given the right to legal representation paid for by the college. At present, of all the lawyers involved in the process, none represent the interests of the complainant. I learned that it is far too complex a system to negotiate without legal advice. Giving the survivor-complainant full-party status with legal representation would ensure a more balanced, equitable process and better, more just decisions. That the colleges absorb the cost of the legal representation should be seen as part of being self-regulating and of being responsible and responsive to the interests of the public. As a public health nurse and a member of the College of Nurses, I fully support this myself.

I would like to speak next to the issue of incompetence. Sexual abuse needs to be seen not only as professional misconduct but also as incompetence. Does not

the use of a patient by a physician to gratify his own sexual needs indicate "a lack of judgement or disregard for the welfare of the patient such that he is unfit to continue to practise," the definition of incompetence as stated in the RHPA? I think so.

The college is presently reluctant to declare a physician found guilty of sexual abuse as incompetent. Fenigstein admitted to incompetence and this was accepted by the panel. Would they have found him incompetent independently? Their record of decisions indicates probably not. The reluctance to make a finding of incompetence means that if physicians who are found guilty of sexual abuse decide to appeal, they are free to practise until the appeal is heard, up to two years. Is this protecting the public? I don't think so.

I would like also to recommend full mandatory reporting, including "behaviour or remarks of a sexual nature." These have no place in a professional patient-client interaction and cause great harm. They are often the precursor of physical sexual abuse as well.

Those who speak against mandatory reporting with professed concern of disempowering survivors are, I believe, mistaken. Survivors are protected by the provision of not having their name disclosed without their consent. A health professional reporting abuse is in fact affirming that person's sense of self by stating in effect, "This is serious, this is unacceptable and must be acted on in order to protect others." It will help her move in the direction of recovery/healing by placing the blame clearly and unequivocally with the offender. This is empowering, not disempowering.

Mandatory reporting need not therefore harm the therapeutic relationship, a fear I have heard expressed by members of the Ontario Medical Association, the Ontario Psychiatric Association and others. It is mandatory reporting, not mandatory participation in the disciplinary process. As well, the fear expressed of mandatory reporting to a system that is harmful speaks to the need to reform the system, not to limit the reporting.

If mandatory reporting had been in effect, many women, including myself, might have been protected from Fenigstein's sexual abuse. Contrary to the assurance made by a psychiatrist to this committee, that profession doesn't act as a shield or protector of abusers. I have been made aware that people in the psychiatric community knew for years that Fenigstein was sexually abusing patients. Mandatory reporting would have given them no choice but to report their knowledge of this abuse. As well, my disclosure to health professionals of his sexual abuse would have been reported to the college.

I would like to speak finally on the issue of compensation to survivor-complainants. I feel survivor-complainants should be adequately compensated for the devastating, far-reaching harm done by sexual abuse from health professionals. Compensation shows acknowledgement of harm done and responsibility taken. I believe that the definition of "therapy" and "counselling" should be broad enough to encompass whatever the survivor finds helps her in her recovery/healing.

I fear a conflict of interest if the compensation fund is administered by the same college that is making decisions

regarding guilt. Perhaps in the interim the advisory council could administer the fund and have the task of setting up an independent body to do so in future.

Funding, I believe, should come from levies on college members—I myself would support this at my own college—repayment of OHIP fees paid to the abuser during the time of the offence and from the physicians found guilty of sexual abuse.

1650

I am glad to have this opportunity to speak before you today. I have grave concerns as to the system now in place that continues to reabuse and traumatize women who come forward to report sexual abuse.

The college has been given the ways and means to make it a more equitable and just process through the recommendations of the Task Force on Sexual Abuse of Patients. To date, they have shown a lack of will to do so. Changes have been made, but they are largely cosmetic and do not improve the complainant's survivor status and rights in the process. In fact, I am afraid the cosmetic changes lure complainants into a false sense of security from which we emerge much later to find that great harm has been done.

Bill 100 is a step in the right direction and hopefully will move the colleges along, particularly if it reflects the concerns and experiences of the survivors and survivor advocates who are presenting before you. If the College of Physicians and Surgeons of Ontario continues on its present course of resisting fundamental change in the process, of showing an alarming lack of understanding and knowledge of sexual abuse and of perpetrators and of continuing its reabuse and retraumatizing of survivor complainants, I believe this points to the need of having this work done by an independent body which is educated, aware and responsive to the issues of sexual abuse by health professionals. Thank you.

**The Chair:** I'm afraid our time is pressing. That was a very thorough presentation and recommendations. On behalf of the committee, we thank you very much for coming here today.

#### ONTARIO DENTAL ASSOCIATION

**The Chair:** I then call on the representatives from the Ontario Dental Association. Welcome to the committee. If you'd identify yourselves for Hansard, and then please go ahead with your presentation.

**Dr George Sweetnam:** The Ontario Dental Association is pleased to have this opportunity to speak with the committee on Bill 100. I am George Sweetnam, the president of the Ontario Dental Association. With me today are Mr John Gillies, our executive director, and Linda Samek, our director of professional affairs.

Because Linda has worked so closely with our members and the many other interested parties on matters related to Bill 100, I want to ask her to outline some of our specific concerns about the current proposals.

**Ms Linda Samek:** The Ontario Dental Association is a voluntary organization which supports dentists in the delivery of exemplary oral health services. Our members recognize the privilege granted to them by society and we pledge to uphold the moral, ethical and professional

responsibilities outlined in the ODA code of conduct. In part, that code states that we shall "recognize and respect the worth and dignity of all persons who entrust themselves to our care."

The ODA believes that dental patients, and indeed all patients seeking health services, deserve to be treated in a safe, non-threatening environment. Ontario dentists support the implementation of legislation that will attempt to ensure that the office is a safe place for patients. We support get-tough legislation that will permit the governing bodies to prosecute abhorrent behaviour. Legislation should provide very clear direction to the colleges, to the regulated practitioner and to the public. We agree that there is a need to prevent sexual abuse of patients.

Sadly, we do not believe the proposals before us will meet fully the important goal of patient protection. We are very much afraid that the public and the media discussions which have surrounded the report of the CPSO Task Force on Sexual Abuse of Patients have led the Ministry of Health to develop an excessively broad and sweeping definition of "sexual abuse." We are concerned that the definition goes too far, that the current proposals will take the care from health care.

We know some will consider our comments insensitive, but we assure you that we take this matter very seriously. It is because we want to have legislation that works that we implore committee members to examine the complexities of implementing the current proposals. We ask you to consider the impact Bill 100 will have on the delivery of health care. The compassionate, calming and reassuring touch that has been demonstrated to be an important part of all healing arts will be deemed forbidden. Practitioners will be afraid that their honest interest in the feelings of their patients will be misinterpreted by either the patient or a third party.

We believe the definition of "sexual abuse" in Bill 100 goes too far with the phrase "of a sexual nature." This phrase is open to an excessively broad interpretation. The definition should be clearer and more reflective of the intent of Bill 100. The definition should not be so broad that it might easily capture the compassionate and caring health professional who is innocent of any wrongdoing. Given the drastic consequences of being charged with sexual abuse, no practitioner should be accused falsely because of poorly worded legislation that might be open to vast interpretation. We don't want the mandatory reporting process to be triggered by any of the 23 other practitioner groups simply because they do not know or understand the full circumstances of a touch in the course of practising any of the 24 regulated health professions. Therefore, we encourage committee members to qualify "touching" so we do not encourage practitioners to erect needless barriers between the patient and the provider.

Further, we do not agree that remarks of a sexual nature should be portrayed as sexual abuse. Let me qualify this by stating very clearly that the ODA does not condone any practitioner's use of loose, inappropriate, offensive, improper and simply stupid remarks. At the same time, we believe that it is the exploitive nature of the remarks that might classify them as abusive.

We recommend that the category of remarks and



behaviour be dropped from the definition of sexual abuse. Here we suggest that you consider the value of verbal abuse remaining as a matter of professional misconduct in the regulations of each of the RHPA providers. As currently outlined in Bill 100, we believe that convictions under the category "remarks of a sexual nature" would be extremely subjective. The rules would be applied differently from complaint panel to complaint panel and from profession to profession.

When it comes to the use of language, we implore you to invest in education to sensitize practitioners and the public to acceptable behaviour for both genders and all cultures. We need to change poor behaviour and empower the public to complain about inappropriate remarks, remarks that would be reasonably regarded as being disgraceful, dishonourable and unprofessional.

As we stated earlier, we need get-tough legislation, legislation that will, at the least, permit our colleges to punish or, as required, to get rid of the very bad apples who violate the patient-practitioner relationship. But we need to do more than merely punish offenders. Prevention strategies are essential.

We recognize the difficulty in defining sexual violations in a responsible manner while balancing the needs of the professions and protecting the rights of the patient. We do not believe that the current proposals will resolve the implementation problems we have outlined.

Our concerns about the definition are heightened by the mandatory reporting requirements. The reporting requirements are central to making this legislation work, and the definition is key to the triggering process.

We have many concerns about mandatory interprofessional reporting as it relates to touching. We simply do not have a comprehensive understanding of the touching that might be common in the delivery of some health services. Honest misunderstanding of the roles of others would create problems for the system and the patient. Patients may wrongly assume that a third-party report deems guilt.

In general, we also object to reporting a practitioner to his or her college without the consent of the patient. We believe that the colleges require detailed information about the incident for appropriate follow-up. We do not believe that unsubstantiated third-party reports will lead to convictions.

**1700**

If we are to stamp out abusive behaviour, we should provide the patient with needed information to initiate the complaint process, and where it is agreed that a third party will be required to file a report, the report should include the patient's name.

Our final comment on mandatory reporting relates to the report of the counselling professional. In the future, will these regulated providers be required to break patient confidentiality when treating members of the clergy, teachers and cub scouts or others who hold a position of trust, or will regulated health care providers remain the only group forced to seek care from the unregulated and unqualified provider?

We do not see any element of public protection in the

requirements to have regulated providers ignore their duty to protect the confidential nature of their patient-practitioner relationship. The end result is more likely to eliminate any possibility of self-initiated treatment that could prevent or stop abusive behaviour.

Finally, we ask for clarification about when the patient-practitioner relationship ends and consensual relations might begin. The bill does not appear to draw any distinction between exploitive, abusive and consensual relations.

The ODA continues to believe that it is the test of exploitation and the abuse of trust that should determine the wrongfulness of the situation. We do not support a blanket approach to banning personal consensual relationships between a patient and their dentist. While the practitioner may need to sever the professional relationship with the patient, we do not believe there is any magic to the three-year solution that has been proposed by some professions.

We believe the Supreme Court decision on this matter is instructive. The two-step test, which includes exploitation, is the legal measure for determining sexual battery in the patient-practitioner relationship. We encourage committee members to explore this matter during your review of Bill 100.

In summary, we agree that we must develop mechanisms to prevent abhorrent behaviour. As an interim step, we support measures that will provide due process for victims and providers: legislation that will permit the colleges to identify and punish practitioners who have been found guilty of sexually abusing their patients. But we cannot move forward without establishing clear definitions of sexual abuse. Both practitioners and patients need to know the rules about appropriate sexual boundaries.

In our view, public education is a key to establishing patient expectation. Because females are the target of the vast majority of sexual abuse in our society, we see the women's directorate playing a lead role in providing related resources to the public. In this way, the benefits will not be limited to the health care setting.

Today we are here to pledge our commitment to work with all parties to implement strategies designed to protect patients. Given the complexity of the matters before us, we encourage further study of this legislation. The expediency of political correctness should not force the adoption of vague legislation.

Finally, given the significance of the RHPA and the RHPA amendment act, we recommend that a comprehensive review of this legislative initiative be undertaken within three years of proclamation.

We thank you for your attention.

**The Chair:** Thank you very much for your submission. We have time for one question.

**Ms Christel Haec (St Catharines-Brock):** Actually, I have several, but I will raise the first one I thought of, and that's on page 2. At the top of the page you talk about "the compassionate, calming and reassuring touch." Having just visited the dentist on Friday for some very necessary work on a molar, I informed him that in fact it



was white-knuckle time, and he and his technician handled it, in a very professional matter, I might add, realizing that I'm not enamoured with having my teeth drilled. But I have to say that in all the years I have used a range of health care practitioners and not always felt calm about the experience, I have never had a doubt that I would be able to tell the difference between professional touch and something that would start to meander into something that would be considered sexual abuse.

Maybe these grey hairs say that I have reached a certain age, which I have, but I do believe that, and I endow the patient with the ability to tell the difference.

**Mr John Gillies:** You're absolutely right. We don't question that in our submission. The concern is not the patient's perception; it's the third party quite often. There's a compulsory reporting aspect. Someone walking by, they see the dentist or some other practitioner with their hand on a patient or if they're reaching around the patient with an instrument, or whatever, they're close to places where professionals shouldn't be touching; there's a very significant concern about the mandatory reporting aspect of a third party in the office, or whatever.

There's also, quite frankly, the definition of what is touching. I can certainly appreciate that anybody can determine, if you're the recipient of the touch, what the intention should be. But that doesn't prevent someone from taking that as an abusive circumstance and reporting it and hoping that they would win the case. Just the fact that it's there and available makes it subject to abuse, and that would be our area of concern.

**Ms Haeck:** I realize the time—I will not proceed with this—but I would like to stress that I don't totally agree with you because I think most people who've had occasion to be in a medical care or health care office would probably be able to tell the difference.

**Mr Gillies:** I would suggest, though—such as nitrous oxide conscious sedation, where patients are under severe sedation, hallucinating or whatever—there are lots of circumstances that give rise to our concerns on a professional basis. We can address that in a submission we'll make in writing in the future.

**The Chair:** I regret that our time has run out. Thank you very much for coming this afternoon.

ONTARIO MEDICAL ASSOCIATION

**The Chair:** I call on the representatives from the Ontario Medical Association, please. Welcome to the committee. If you'd be good enough to introduce yourselves, then please go ahead.

**Dr John Gray:** Thank you. We were concerned initially that the Ontario Medical Association in fact would not be given an opportunity to appear before this committee. You'll recall that we were originally slotted for November 23, and actually Dr Graham and myself were here and ready to speak, but we didn't learn until late in the day that we would not be given the opportunity because of the limited hearing time. We're thankful, because you've moved into extended hearings, that our name has come up and we are able to speak.

My name is John Gray. I'm a family physician from Peterborough. I'm a member of the board of directors of

the Ontario Medical Association and also chair of the OMA committee on sexual abuse issues. With me is Dr Wendy Graham, who's also a family physician, from North Bay. Wendy is a member of our committee on sexual abuse and is also chair of the OMA committee on women's issues.

The OMA's formal submission to this committee has been given to the clerk, and I trust it's been circulated. We've decided today not to review or summarize that submission in our verbal presentation, although we would be happy to answer any questions you might have. Instead, Wendy will start off by talking about the underlying current that flows through the government's approach to sexual abuse in the health care sector, and I'd like to close by talking about the process that's brought us to this point.

**Dr Wendy Graham:** I want to talk to you briefly about what Bill 100 says to me as a female practitioner and as a woman. The vast majority of physicians became doctors to heal, to provide sound, trustworthy, nurturing and effective care. As the minister stated in her speech in the Legislature on second reading, the vast majority do just that.

We all want to get rid of abusive health care practitioners, get rid of practitioners who exploit their position of power and trust. We support heavy penalties for abusive practitioners and we support measures that will deter, identify, discipline and root out sexually abusive practitioners. There is no place for such people in medicine, but there is an implicit assumption in the theme of Bill 100 that is wrong and offensive: that sexual abuse is only a women's issue rather than a societal issue, and that women as a group require the protection of the government.

In fact, sexual abuse involves children of both sexes, as it involves men as victims too. Most women are neither victims nor want to be seen as victims nor want to be treated as victims. We do have to do more to train and educate health care practitioners and health care consumers about their rights, how to exercise those rights and how to distinguish between sexually abusive or offensive behaviour or touch and what is therapeutically necessary and accepted. We have to rebalance the relationship between the practitioner and the patient. Bill 100 doesn't do this. In fact, it may deter the progress in this direction. It is impractical to legislate attitudinal change.

1710

We agree that sexual violation and sexual touching, because of wrongful intent and harm, are unambiguous and must be mandatorily reported. But what about remarks and behaviour; remarks and behaviour that may be misunderstood, where there is no intent to harm or cause offence and where no offence is caused; remarks and behaviour that are irritating, ignorant or offensive, but not sexually abusive? One of the most offensive and intrusive aspects of this legislation is that it takes away from the patient's right to decide how they want to respond to remarks and behaviour that are offensive or abusive. In fact, in that respect Bill 100 disempowers and dehumanizes patients—men, women and children.

I am very concerned that Bill 100 will deter patients from seeking treatment for sexual abuse. They will rightly be afraid that if they do, regardless of their wishes, a report will be generated and the system will take over. This not only revictimizes the patient; it will likely neutralize whatever therapy is being provided. We have to recognize that most victims of sexual abuse require a great deal of therapy and treatment before they are either ready or able to come to grips with the abuse or challenge and confront the abuser. Victims of sexual abuse must be able to find a safe place for treatment, and that safe place must include the regulated sector if they so choose.

Somehow, Bill 100 got mixed up in its objectives. It set out to deter, identify and discipline sexually abusive practitioners, and that's something we all support. But patients' rights, patients' privacy and patients' self-determination somehow became subordinate in the request, and that's wrong. Those ends don't justify the means. Victims have rights too; they don't lose their rights as a consequence of being sexually abused. But that's exactly what Bill 100 appears to do. We don't think this is right.

In this regard, the OMA supports the position of its section on psychiatry in the letter to Paul Wessinger dated December 3, 1993. On page 3 of that letter, the section on psychiatry has stated:

"Finally, in the case of the competent patient, able to speak with free will, who refuses permission to report, should a psychiatrist have the obligation or even the right to report, should the government be able to legislate disclosure, should victims' groups, victims or anyone else be able to dictate reporting? More simply put, must the psychiatrist, government, victims' groups or anyone else have to speak for this patient, or should this patient be allowed to speak for themselves? Should not this patient have a choice?"

We are very concerned that mandatory reporting for remarks and behaviour will deter self-referral by abusive practitioners seeking help for their problems, because they'll know that when they seek help, a report will be generated by the treating practitioner.

I am also very concerned with the growth of gender sensitivity in health care that's leading, in my opinion, to gender discrimination in health care. We are on the verge of creating a system where male doctors deal with male patients and female doctors deal with female patients. The result is not good for women, because it will mean that many women will be denied the health care that they need, where they need it and when they need it.

I want to put to this committee some of the questions our members are asking us: Will Bill 100's prohibition against touching or remarks of a sexual nature chill a physician's ability to provide effective care? Will these prohibitions increase physicians' reluctance to perform certain clinical examinations that would normally be appropriate? Will they increase the physician's reluctance to raise or respond to patients' concerns or questions about sexual behaviour? Will they disempower women patients from seeking counsel or treatment for sexually sensitive ailments?

We are not naïve. The fact remains that Bill 100 will go forward largely as it is. The government's attitude over the past year has made this abundantly clear. But in good faith, we want this committee to understand what we fear Bill 100 will do. It will not be as effective as it could have been. In fact, we've already seen evidence of Bill 100's negative impact on the physician-patient relationship. Bill 100 will have consequences for health care that no one in the practice of medicine wants or that health care consumers, if they really knew, would want.

I'll turn things back to Dr Gray.

**Dr Gray:** Although the medical profession was slow to come to grips with the extent of sexual abuse and its impact on patients, the work done by the OMA and by the CPSO has been critical in the development of Bill 100. We were pleased that this was acknowledged by the government task force and by the Minister of Health in her speech at second reading.

However, on November 24 in this Legislature, a member of this committee was quoted in *Hansard* as saying: "I think enough is enough. I think it's time we said, 'We've had our chance.' We've worked two years on this particular piece of legislation. It's been held up time and time again in committee."

In light of that comment, I think it's important to review some of the events that have brought us to this point. Keep in mind that the final report of the CPSO task force was released on November 25, 1991. The college itself released its final recommendations on the report on September 15, 1992.

An interministry working group was established in response to the college recommendations and issued the government white paper, *Taking Action Against Sexual Abuse*, on October 8, 1992. That report dealt with 29 of the 60 recommendations made by the CPSO.

On October 28, 1992, the Ministry of Health sponsored a round table discussion on the *Taking Action* document. It is important to note that this was the first opportunity for associations and colleges outside of medicine to discuss the issues being raised and the actions being proposed. This was a little more than 13 months ago.

November 6, 1992, less than a month after its release, was the deadline for affected or interested groups to respond to the *Taking Action* document, and on November 25, 1992, about two weeks later, Bill 100 was tabled in the Legislature. On July 29 of this year, Bill 100 went through second reading in less than two hours of debate and was referred to this committee on that day.

From the commissioning of the CPSO task force to now is about three years, but for the other regulated professions, close to 50,000 practitioners, the process to this point has been just slightly more than one year. All of us saw Bill 100 for the very first time one year ago, and it's scheduled to pass and be proclaimed before this month is out.

We ask you to compare that to the Health Professions Legislation Review, which has taken 11 years now and is still not complete, or the tobacco control legislation, which has been promised for two years and was tabled for first reading just a few weeks ago, or the legislation



on graduated licensing, which has been in the mill for over two years.

Bear in mind as well that there have been abrupt and significant changes in direction in the approach to sexual abuse in the health care sector over that same period. Bill 100 contains major and unexplained changes from both the CPSO task force recommendations and the government's own white paper, *Taking Action*. The ministry has floated, from time to time, proposed changes to Bill 100, but the extent and precise nature of amendments have never been clear.

As an illustration of the type of confusion we have had to deal with, at our last consultation session the participants spent considerable time and energy debating the ministry's proposal on remediation, only to be told at the end of the day that the wording the ministry intended was not the wording set out in the papers the ministry had circulated for the consultation. The difference in wording was so great that it meant that the time spent had been largely wasted. At times we've asked the ministry for explanations of what certain clauses of Bill 100 mean or are intended to mean, only to be told, "We don't know" or "We're not sure."

The points I wish to make are these:

This bill, in fact, has come together remarkably quickly. Any delays in bringing this bill forward are not attributable to victims or to survivors, to the health care associations or to the regulatory colleges. In fact, the government itself has acknowledged several times our leadership role in addressing this issue.

We think that victims and survivors, the associations, the colleges, health care consumers and the public have been denied due process in Bill 100.

We've been working with a target that has been sometimes moving, at other times obscure.

We have not had the opportunity to examine alternatives and options. Given the very short time between the release of the *Taking Action* document and the tabling of Bill 100, it's fairly obvious that the government's mind was made up.

We have not had the opportunity to express our views fully and effectively to the government. We have been restricted to 15 minutes in our presentation to this committee. A number of groups that wanted to appear before this committee have not been able to. We understand that this committee has only one day to conduct clause-by-clause of this bill and to consider the host of amendments that have been proposed, including our own. After one day of committee hearings, the time allocation motion was applied to limit debate at third reading to two hours.

1720

We have not had the opportunity to fully consult and effectively consult with victims and survivors in an attempt to arrive at consensual and cooperative solutions and understandings to enhance the effectiveness of any legislation.

If there was general support for Bill 100, denial of due process wouldn't matter so much, but Bill 100, in our view, is seriously flawed. As a result of these flaws, it will not achieve the objectives of government, the victims

and survivors of professions, or the objectives of the regulatory colleges. You've heard that in testimony before this committee day in and day out. Bill 100 has done a remarkable job of falling short of the expectations of nearly every constituency.

To be effective, Bill 100 must be and must be seen to be a balanced, appropriate and effective response to the very serious issue of sexual abuse by health care practitioners.

It is very intrusive legislation. The colleges and associations have spent a lot of time studying Bill 100 from very different perspectives and have all arrived at much the same conclusion. Bill 100 is not seen by health care practitioners as fair, measured, or likely to be effective.

Because discussion of Bill 100 has been foreclosed, because the government has decided to give short shrift to our objections, our concerns or our alternative solutions, this legislation lacks the credibility that is essential to its implementation.

There is no reason for this haste. There is no particular reason that Bill 100 has to be proclaimed with the RHPA. There is no particular reason to foreclose the discussions and consultations on Bill 100 that were beginning to bear fruit. Bill 100 is important legislation. It had potential to accomplish something worthwhile. It merited more careful consideration.

Although this legislation has been developed in haste, it will have long-term impact. This rush to judgement on Bill 100 will have negative impact on innocent physicians, on vulnerable patients and on our health care delivery system.

We'd be happy to respond to any questions.

**The Chair:** We're tight on time but we do have time for one question.

**Mr Jim Wilson:** You've given very strong comments and strong condemnation of the bill.

I have great sympathy, and expressed it in the limited debate we did have in the Legislature on second reading, with respect to the time frame here. I too don't understand why the government is in such a hurry to proclaim this at the same time as the RHPA 1991, because there are problems with it. Whether people like it or not, it's the health care professionals who have to make this bill workable, and they are telling us repeatedly that there are a lot of flaws in the legislation.

I had a very interesting discussion last night with some people who thought they knew a lot about this legislation. In mandatory reporting, and particularly, as you've mentioned, referral to your psychiatry section, there seems to be an impression out there that this bill will catch sort of all the crimes committed by health care professionals.

In, for instance, the mandatory reporting in the course of psychiatric treatment, I said to these public persons: "What happens in the case of murder? If somebody appears, whether it be a patient from the general public or a health care professional who's requiring psychiatric services, psychotherapy, there's no mandatory reporting of murder. There's no mandatory reporting of rape."



I want to ask you specifically that question. If someone were to admit having raped a patient, and this abuser is receiving psychiatric treatment, for example, then there's the mandatory reporting. We had a great discussion last night whether that goes strictly the sexual abuse discipline route or whether it continues to be a criminal matter. The abuser should be hung, in my opinion, for that conviction.

There seems to be a lot of confusion out there. People are seeing this bill as a cure-all for getting all of the abuse out of our system. It seems to me that for some reason, we've taken sexual abuse, put it on a pedestal and said, "This is the most important and most heinous crime occurring among health care professionals."

I only raise that as a general point because, you're right: If we had more time, we actually might be able to do some good for society with respect to all the harm that's going on out there. We've taken a very narrow issue, which does concern a lot of people, I agree, but there are many other things that you would hear in the course of your duties that are heinous crimes to society and yet you have no mandatory reporting there.

I just want you to comment on what I know is somewhat of a rambling statement but it's somewhat of a frustration when I talk to people who think this is somehow a cure-all and a great step. I have my doubts about that.

**Dr Gray:** I think you've touched on a point which is a sore one for the profession—in our case, doctor-patient relationship, but in all of the other health care professions. Particularly psychology, and others, feel very strongly that the doctor-patient relationship and confidences that are disclosed during the course of that relationship are sacrosanct. Society has in fact intruded through legislation on to that confidentiality provision on a few occasions. By and large, the professions support it if the profession at large believes that the good of society is necessary for this kind of intrusive legislation; for example, the mandatory requirement to report child abuse, the mandatory requirement to report unfit drivers and so on. We accept the intrusiveness on to the doctor-patient relationship if we honestly believe the good of society outweighs the sanctity of that doctor-patient relationship.

You touch on heinous crimes, and I quite honestly can't believe those sorts of issues won't be raised in the future. At the moment, we are only obliged to report certain incidents.

Our profession does not support mandatory reporting of the words and gestures issue because of the difficulty in interpreting exactly what those words and gestures meant from the doctor's mouth and how they were interpreted by the patient. Because of that uncertainty, we cannot accept the fact that it should be allowed to intrude on the sanctity of the doctor-patient confidentiality.

**The Chair:** Thank you very much. I'm sorry we don't have more time for questions at this point.

SIMCOE LEGAL SERVICES CLINIC

**The Chair:** I would then call on Simcoe Legal Services Clinic. Welcome to the committee. If you would identify yourself and then please go ahead.

**Mr Ian Cameron:** My name is Ian Cameron. I am the staff lawyer at Simcoe Legal Services Clinic in Orillia.

I have prepared some submissions which have a green cover. You may have received copies, and I'm here today to talk primarily on the issue of compensation as opposed to some of the other issues that have just recently been discussed before you today.

I should point out an error in the numbering. If you turn to the table of contents—it's the second page in—the conclusion that I'm asking for is amendment of subsection 85.7(1) rather than (4), for those of you who may have already spotted that error, and again on page 9 the same error appears in the heading; it should be (1) rather than (4).

Let me say that my experience in relation to all this comes from doing a lot of criminal injuries compensation for victims of crime. As a result of that sort of work, I became involved in the consultation process that's recently been ongoing about Bill 100, because it does contain provisions for compensating victims of crime. I say that because, as you no doubt have already heard exhaustively about the definition of "sexual abuse of a patient," there are a lot of things described in that definition which are crimes.

The next proposition I wanted to put to you is that if they are crimes, then there is considerable overlap between what's compensable by the Criminal Injuries Compensation Board and what's compensable under this legislation. In fact, in many cases with respect to sexual touching or sexual intercourse between the doctor—I'll choose to say the word "doctor"—and the patient, they would have the option of going to the Criminal Injuries Compensation Board to seek compensation for that event. As an encounter which takes place where there's a power imbalance, where's there a breach of trust, I can live quite easily with that as an application to the Criminal Injuries Compensation Board.

1730

Therefore, I come to this committee to contribute the observation that there is considerable overlap between the compensation eligibility under the Compensation for Victims of Crime Act and that which is available under this enactment.

Once you make that key observation, then it's quite evident to me as a practitioner who's going to have victims coming into his office that I'm going to recommend that they go to the Criminal Injuries Compensation Board rather than to go to the college. The differences between what's available, the task that it represents for the victim, everything, suggests that as a source of compensation, this process is useless.

In my paper I've examined subsection 85.7(4), which describes the compensation process, and I invite you to share with me my conclusion, which is that probably one person out of 10 will actually make it all the way through to the compensation order you're talking about in this legislation. One in 10 would be generous. Ms Brown was up here just a few minutes ago talking about one person's case going forward and another seven not going forward

and a further 19 known of but nothing done with them. That comes out to less than one in 10 when I do the math. So what I'm saying here is that the compensation issue is a tempest in a teapot. It's going to affect such a small minority of individuals that unless you change that, it's not even worth your while to consider what else is wrong with the way in which the compensation scheme is set up.

The reason behind it is simple. Although there's provision in the act to provide for an alternate means to assess eligibility for compensation, it depends for its existence on the college in question making a regulation. They don't have to do that if they don't want to. So it should come to you immediately, in my submission, that they're not going to. If they don't, then the only cases that are going to be compensated are those which pass through the entire discipline committee process right to the very end—and that includes those which are plea-bargained away—and the final submissions at the end of the day. That's the key argument that I'm presenting here and that I've documented.

Then I've gone on to compare the difference between what's available in terms of compensation to victims under this legislation and what is available under the Compensation for Victims of Crime Act. I've set out in here the distinction with respect to procedure, with respect to evidence, with respect to burden of proof and with respect to the powers that victims have with the process at the Criminal Injuries Compensation Board as opposed to what's available to victims under this legislation. The Criminal Injuries Compensation Board wins hands down, straight across the board.

For instance, just on the quantum of compensation, we've been told \$10,000 is probably what we're looking at to purchase from third parties some therapy or counselling. Now, the Criminal Injuries Compensation Board, in the case of people who suffer multiple sexual assault, typically awards two years' therapy. That alone duplicates or exceeds the value of what's available under this legislation, and that's before you begin the assessment of pain and suffering. So the pain and suffering is on top of that. I would say again, with multiple sexual assaults or multiple offenders, you're looking at in excess of \$10,000. Even a very simple approach to the board will produce probably \$10,000 in pain and suffering. That's clearly superior to what you're suggesting should be given to victims under this legislation. If they're interested in compensation, they're simply not going to pursue this route, with all of its tortuous twists and turns, when they can go to the Criminal Injuries Compensation Board and obtain the same remedy probably without a hearing, probably on the basis of documents alone.

In my office 90% of the cases we handle from the Criminal Injuries Compensation Board result in a finding of pain and suffering in excess of \$10,000, with the two years' counselling on top of that without a hearing, on the basis of documents alone.

Once you hear that, you've got to know that, trying to compare this process with that, your objective is to get resources for people so that they can overcome the impact of victimization and get on with their lives, if

that's what your goal is, you're clearly not going to go through this process, not unless you've got extra energy left over after you've used the Criminal Injuries Compensation process.

The focus, if I can call your attention briefly to page 9 of my submissions, sets out there what it is that I would ask you to do, and it involves an amendment of a particular section that simply requires the college to prescribe this alternate procedure. That's all I'm asking for, because if you don't do that, you might as well not even bother dealing with the other very important issues that I'm sure have already been raised for you today about the compensation process, because it's only going to affect a very small number of people.

What I'm asking there is to require the college to prescribe the alternative requirements for assessing eligibility. It has given them power to do it, but you haven't given them any obligation whatsoever. In my submission, they're going to be looking for a way to avoid those expenses, and they can do so simply by failing to pass a regulation.

There's some precedent material in the paper which talks about a similar situation arising in the unemployment insurance legislation where that exact circumstance occurred, so there's legal authority for the proposition that I'm advancing with respect to that issue.

I've summarized at page 3 of my submissions a list of the various dead ends and blind alleys that you can end up in as a result of this discipline process that lead to something other than a finding by a discipline committee. I make this point, a finding by an executive committee, a finding by a fitness to practice committee, a finding by a complaints committee, there could be all kinds of process at the college that doesn't have anything to do with a final finding by a discipline committee. It's only at the end result of that process that you're going to see compensation paid.

You have a winnowing of cases, you have a reduction from 19 down to one. The other 18 are getting nothing and the other 18 are going to be going to the Criminal Injuries Compensation Board instead. Their funding will therefore be paid by the Legislature, so what you're doing is you're being generous, in my submission, with the money that you have charge of here in the Legislature, because the other people whose complaints are developed but which are not pursued through the discipline committee will be able to take the development of that complaint across the street to the Criminal Injuries Compensation Board and basically redeem it for cash. That's what's going to happen in this case.

I think I can speak strongly—I am speaking strongly and I appreciate that—in my office. I think we close approximately 50 to 60 Criminal Injuries Compensation files a year, and we're very frequently successful. Very rarely is a Criminal Injuries Compensation application unsuccessful. Currently, if you look at their statistics, and again you'll find them in the package, well over 90% of the people who apply to the Criminal Injuries Compensation Board are successful. Can this discipline process boast that kind of success rate? I don't think so.

I think you're going to have a difficult time competing



with the Criminal Injuries Compensation Board for business as it stands, but in particular, if you give the college the right not to provide another means to compensate these people, then it's all over. There's no competition at all, and the money's going to be spent by the public; it's not going to come out of the professionals' pockets. That's the one message I want to leave with you today. It's much more important than all the rest of this stuff, because when we're talking about these people as disabled people, these people have been disabled by these experiences and they need this compensation.

That's what I came here to say. I'm quite happy to hear any questions.

**The Chair:** As the Chair, I regret very much that we have some real problems and I appreciate the brief that you've left with us, but we're going to have to move on and I'm going to have to explain to members of the committee that we are running into some time problems. Some witnesses have agreed to come after the break but, regrettably, there are other things that are going to be happening in this building which are going to take away the television and other parts of this. I want to make sure that other witnesses have—

**Mr Cameron:** I quite agree. That's why I spoke fast. If there are any questions people have, I'd be quite happy to hear them. You could call me.

**The Chair:** I am in the hands of the committee, as always, but I am in a very difficult time bind and I regret that very much. Thank you for your submission.

1740

#### TRANSITIONAL COUNCIL FOR THE COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

**The Chair:** If I could call on the representatives from the Transitional Council for the College of Respiratory Therapists of Ontario, I just note for those who have a schedule that Miss Robyn Johnson will be appearing later. We have two more submissions, the one from the respiratory therapists and then the Ontario College of Family Physicians. That will end our first part and then we will continue with the other witnesses.

Please go ahead and introduce yourselves.

**Ms Margaret Carter:** My name is Margaret Carter and I'm the vice-chair of the Transitional Council for the College of Respiratory Therapists, and this is Linda Bohnen, who is our legal adviser.

The mandate of the College of Respiratory Therapists of Ontario is to regulate the profession of respiratory therapy in the public interest. In fulfilling this mandate, the Transitional Council for the College of Respiratory Therapists must meet the requirements of Bill 43, Bill 64, and now that mandate also includes administering Bill 100. It is with respect to Bill 100 that we make this submission. Our concerns are based on our knowledge of the college membership and the role that our members will play in the health care field.

First, a little information about the profession. Respiratory therapy is a relatively new health profession. In Canada the profession is approximately 30 years old. The beginning was as individuals responsible for oxygen tank delivery. Through the years, the profession has expanded

to where it is today, active in the care of patients ranging in age from premature newborn babies to the elderly. Today respiratory therapists may be found monitoring and maintaining life support equipment; responding to emergencies like heart attacks, respiratory arrests and traumas; assisting patients with diseases like emphysema, cystic fibrosis, asthma, chronic bronchitis and pneumonia; helping patients with ALS and polio remain at home enjoying a quality life; providing diagnostic testing including lung function, cardiorespiratory function, sleep studies and stress testing; assisting in the operating room to ensure that the equipment is maintained and the patient is safe; and assisting in the newborn nursery to ensure that premature infants with immature lungs have the best chance for a normal, healthy life.

Contact with clients or patients takes place in a variety of settings: acute care hospitals, outpatient clinics, diagnostic laboratories, rehabilitation hospitals, long-term care facilities and in the home. Contact may also be short term as in acute or emergency care, or it may be long term as in rehabilitation and home care. It is important for our discussion to realize that respiratory therapists are often alone with a patient or client in unsupervised, one-on-one practice. This is particularly true with the increasing trend to community-based care.

Respiratory therapists number approximately 1,100 in Ontario, with about 35% male and 65% female. The average Canadian salary, according to Statistics Canada, is approximately \$38,000.

The transitional council has zero tolerance for the abuse of patients. Because its intent is the same, the transitional council supports Bill 100 in principle. We do, however, have some concerns about the bill.

Our major concerns are related to the workability of the bill. These concerns are based on the experience of current regulatory bodies, independent legal counsel and our knowledge of the profession. We support the position presented by the coalition of colleges that has been tabled before this committee. We would like to take this opportunity to expand upon some of the issues that we see will impact on our small college. We have outlined our position in the submission but do not wish to waste time in reviewing all of our points. I will focus on those issues that are of particular concern to our college.

First and foremost, we want a law that enables successful prosecution that withstands appeal to the courts. We want a law that successfully deters and, with education and social change, eliminates the abuse of patients or clients. To this end, the transitional council and the college are committed to an educational process that increases the awareness and sensitivity of the membership to the issues of patient abuse.

The college intends to provide guidelines for professional conduct with patients or clients. These guidelines will need to address such issues as when a patient is a patient and when they cease to be a patient, and when is a relationship with a former patient consensual and when is that patient or client vulnerable such that the possibility of a consensual relationship is negated.

Education of the members and of the public may also reduce the potential financial impact on the health care



system of respiratory therapists who feel safe from accusation of abuse only when they are paired with another health care provider.

Of particular concern to us are the following:

**Period of public access to sexual abuse finding:** To protect the public of Ontario, the transitional council feels and believes very strongly that there should be lifetime access to the record with respect to findings of sexual abuse.

**Non-party participation:** The transitional council does not want the bill to be changed with respect to non-party participation. Discretion to allow or not allow non-party participation must remain with the discipline committee.

The transitional council is committed to establishing a complaints process that is as user-friendly as economically feasible. After surveying current practice and using information from the meetings with survivors, the transitional council will make every effort to make the complaints process as participative and supportive as possible without compromising the possibility of an effective prosecution. We do not want to risk losing any case on appeal.

The transitional council also supports an appeal provision that provides for appeal on points of law only. It is very important that the peer review process not be undermined by a legal system that is not aware of the finer points and expectations of the profession.

To confer automatic non-party participation circumstances the process of self-regulation that is conferred by the RHPA, self-regulation means that the profession regulates itself. Built into RHPA is public representation that is reflected across the membership of the council, committees and panels. When the college disciplines or regulates a member, this is self-regulation. When a third party prosecutes the member at the same time, self-regulation ceases.

The transitional council also supports the use of victim impact statements once a determination of guilt has been made. It is very important that these statements not be filed with the committee before it has made its finding.

Our last point is funding. The transitional council finds that there is an inherent and fundamental conflict for the college to administer a fund that is initiated by a finding of guilt by a panel of the college. The transitional council feels that it is the same as being judge, jury and money holder. The perception will always be possible that a decision of any disciplinary panel may be suspect in that the public may perceive a protection of their own if a decision is in favour of the practitioner, and the membership of the college may perceive that every decision in favour of the college is because the members of the panel are concerned that they may be accused of conflict. It is our belief that the perception of a conflict is as dangerous and damaging as an actual conflict. This issue may increase the risk of appeal of decisions, thereby increasing the cost and perhaps subjecting the survivor to unnecessary additional trauma.

Administering a fund for treatment is not the function of a college. Additionally, even with the limit of approximately \$10,000, it is possible with the size of this college

that one case of multiple abuse may bankrupt this college and either put an onerous burden on the members or cause the college to cease to exist. We can't be convinced that this is in the best interest of the public of Ontario. The public of Ontario is best served by a college that is determined and successful in removing perpetrators from the profession.

The transitional council could support a funding mechanism that is at arm's length from the profession, where funding is for treatment only and where there is accountability for non-regulated health professionals if they are to provide treatment at the wish of the survivor.

On behalf of the transitional council, I would like to take this opportunity to thank you for allowing us to make this presentation outlining our position of zero tolerance for patient abuse and our concerns about some components of Bill 100.

**The Chair:** Thank you very much. Again, I regret our time problem. I'm afraid we're going to have to move on, but I appreciate you coming before the committee today.

1750

#### ONTARIO COLLEGE OF FAMILY PHYSICIANS

**The Chair:** If I could then call on our final representative, from the Ontario College of Family Physicians.

**Dr Marlene Spruyt:** The other person will be here momentarily.

**The Chair:** She's coming after the break. Miss Johnson has agreed to come after the break. Our problem, and I regret, is that we are going to lose our ability to transcribe and to have the proceedings carried, and that's why I've asked witnesses who can appear after the break, just so we make sure we give them their full time.

**Ms Cheryl Katz:** Sorry. It's just that our note said it was 15 minutes.

**The Chair:** Welcome to the committee. We've had to make a change just to make sure we can cover everyone.

**Ms Haeck:** Just a quick clarification: You're mentioning that we will be losing the ability to transcribe?

**The Chair:** As soon as we're finished with this witness.

**Ms Haeck:** We'll be having a recess, and for some reason there will be no ability after that?

**The Chair:** There will be when we come back. It's just during the period from 6 to 7 because of the ceremonies that are going on in the main hall.

**Ms Haeck:** All right, but we're not meeting in here anyway.

**The Chair:** Not till later, when all of this will be back.

**Ms Haeck:** Okay. So it's not a matter that the people this evening will not be on Hansard.

**The Chair:** No, it's simply that during this break there is the ceremony of the lights, and I'm afraid it's just trying to get all the technology together.

**Ms Haeck:** I just wanted to make sure my understanding of it was clear.

**The Chair:** Everyone will be seen and heard who is on the list, including Miss Johnson.

**Ms Haeck:** Very good. Thank you.

**The Chair:** Welcome to the committee. If you would be good enough to introduce yourselves, go ahead.

**Ms Katz:** Thank you very much. Good evening. I'm Cheryl Katz. I'm the executive director of the Ontario College of Family Physicians. With me is Dr Marlene Spruyt, who's the president-elect of the Ontario College of Family Physicians.

I have had the opportunity of perusing some of the submissions that have been presented before you, and I'm impressed by the scope of coverage, that these submissions have taken the time to evaluate Bill 100 to the extent that they have. Rather than come before you and re-present on issues that in quieter moments you probably admit you've heard ad nauseam, what we would like to do is touch on some of the issues that we feel impact on the implementation of this bill.

The other thing that struck us when we were reading through these submissions is, rather than the discord between them, we were struck by the cohesion of the submissions. What we felt was that there's tremendous support for Bill 100 and tremendous cohesion around the issue of the purpose of the bill and the philosophy of the bill of zero tolerance.

It occurs to us that the difficulty we're faced with now is not in terms of this legislation, the philosophy of this legislation, but rather in terms of striking a balance between the varying interests that represent the mechanism for implementing this bill.

What the Ontario college has done in addressing some of these issues is attempted to find a reasonable logical balance that might achieve the philosophies that the bill represents. We recognize that some of these issues dealing with mandatory reporting, the definition of "sexual abuse," are all going to be decided by a particular group, depending on where its interest lies. It was the Ontario college's feeling that the difficulty was in determining the balance between often competing interests.

I hope as well that I've just demonstrated the importance of a preamble.

The Ontario college is a voluntary, not-for-profit organization. Our membership consists of over 5,000 Ontario family physicians. Approximately 37% of our membership are female practitioners. We are a provincial chapter of a national organization whose mandate is to promote high standards of medical care and education in family practice.

The Ontario college supports this bill. We believe that any measures that are aimed at addressing and redressing sexual abuse of patients by health professionals who are in fiduciary relationships with their patients is a step in the right direction and certainly long overdue.

The rights of survivors have been historically unheeded and we sincerely endorse measures that will remedy this injustice. However, we believe that overzealous drafting of this legislation will have the effect of swinging the pendulum to the other extreme. We have heard from our members that the fear of Bill 100 and its implications has already compromised women's health care. We also have

a concern that by swinging the pendulum in the other direction to the other extreme it will only prolong the suffering of victims and survivors of sexual abuse who've been victimized by their abusers and who may well be revictimized by encumbered administrative and quasi-judicial processes and by legislation which becomes entangled in lengthy constitutional debate in appellate tribunals.

We recognize that the challenge in drafting this legislation is to achieve a balance between often conflicting interests. The balance of my comments will be aimed at suggesting where that balance might lie.

In terms of the definition of sexual abuse, we're concerned that a broad definition such as includes inappropriate or demeaning remarks and behaviour, also known as sexual harassment, is a different category of offence from sexual abuse. It's our opinion that, with respect to sexual harassment, after-the-fact disciplinary processes are inferior to proactive education and sensitization programs which we believe, in the long run, will more readily achieve the goal of zero tolerance and minimize the risk to others at a fraction of the cost.

In fact I was struck by an editorial in the Toronto Star, November 27, discussing the Walter Hryciuk inquiry. The comment at the end of that editorial was that warnings, suspensions and education would be a most welcome addition to the current system that requires a judge to be removed for misconduct.

It is with respect to education that the Ontario college feels there ought to be a greater emphasis, and that by including sexual harassment in the definition of sexual abuse and turning the matter over to a disciplinary process, you will be missing the opportunity to address and perhaps re-educate individuals who may not necessarily have the intent to abuse victims.

We also believe that a broad definition would encumber administrative structures such that the bureaucratic machinery would not be in a position to address and successfully adjudicate the more serious reports and complaints dealing with sexual abuse. One need not look beyond the experience of the Ontario Human Rights Commission itself as an example of how bureaucratic machinery, albeit well intentioned, can become or has become bogged down in the less difficult, the less severe, issues of discrimination.

We would hate for that to happen because it seems that everybody here agrees that Bill 100 intends to redress difficult areas that have not been touched on and that need to be redressed. We don't want this position to be construed as negating the impropriety of sexual harassment. We just feel that this legislation is not the place to do it, that in fact regulated health professions still have the avenue of unprofessional conduct and that is open to discipline for anybody who is conducting themselves in an unprofessional way, and that would include sexual harassment.

With respect to mandatory reporting, once again, we felt that if there was a possibility to come to some kind of grip with a balance between conflicting interest, that balance would better achieve the goals of zero tolerance. In respect to this section, we understand mandatory



reporting to mean a report of sexual abuse filed by a member of a regulated health profession against another member and a complaint to be report of sexual abuse filed by a patient.

The Ontario College of Family Physicians supports mandatory reporting. Physicians are not strangers to the requirement to mandatorily report: They do so under the Highway Traffic Act in the issues of fitness to drive; they do so in respect of child welfare legislation. Mandatory reporting is no stranger to physicians.

1800

The problem that the Ontario College of Family Physicians sees with respect to this provision in Bill 100 is that, while there may be an opportunity to then perceive a pattern of behaviour with respect to any given individual, it doesn't necessarily promote the goal of zero tolerance to have a document sitting on a file somewhere in a disciplinary body and not to be acted on until perhaps some time later something happens to trigger it. We feel that this is an opportunity, it's an invitation, for the abuse to go on. If there is a way of addressing—and I'll be touching on this in a moment—and stopping the abuse, then it should be acted on immediately.

The balance that we feel is important to strike is based on natural justice requirements. It was felt that at the very least, the fact of a receipt of a victim-initiated complaint or of a mandatory report must be disclosed to a health professional against whom it is made, together with sufficient detail to enable the accused professional to address the allegation and respond to it.

We recognize that there may be victims who are unable to deal with the process if their names are disclosed to health professionals. We struggled with this and felt that a fair balance might be reached in respect of this class of victims if there is a discretionary provision introduced into Bill 100 that would enable the disciplinary body, having been advised by the reporting health care professional, to withhold the name of the victim on the condition that there is sufficient other detail that would enable the health professional to still make a full answer.

We also strongly believe that there must be a mechanism developed within the legislation to enable psychotherapists and psychiatrists to be exempt from mandatory reporting. To do otherwise might result in those providers of health care who recognize that they do have a very serious problem not to seek treatment. Once again, the need for this exemption recognizes the painful dilemma with which one is faced in attempting to balance compelling but none the less competing interests. The philosophy of zero tolerance tips the scales in favour of the need for this exemption.

With respect to intervenor status, it's the position of the Ontario college, which does not support discretionary intervenor status, that by introducing intervenors you may indeed have the effect of obfuscating and diffusing the issue, prolonging the proceeding and delaying appropriate and just decision-making. We don't feel that this is in anyone's best interests, least of all the victim's.

The question of the victim's character in respect of a sexual abuse complaint, in our respectful submission, is

irrelevant to the determination of whether a health care professional's conduct was sexually abusive. It is our position that the issue of character is irrelevant and it should simply be ruled inadmissible. It's unfortunate the criminal courts haven't followed that procedure as well. It is irrelevant what the victim has done in his or her past to the determination of whether or not an act or omission of a professional is abusive.

With respect to funding for counselling or therapy, we don't support the idea that each regulatory body should set its own fund. We are of the opinion that a generally administered compensation fund similar to the Criminal Injuries Compensation Board's would be a more equitable fund. We feel that a generally administered fund would have the advantage of allowing for standardized guidelines to be developed with respect to the disbursement and accountability for funds, and we feel that it would lend itself to established criteria and not depend on the financial status of each profession.

We believe that sources of funding should include fines levied on perpetrators, and we believe that the issue of entitlement, if any, to funding for counselling or therapy should be determined by the disciplinary tribunal which is already in possession of the relevant details and facts to avoid duplicitous proceedings.

We support the use of victim impact statements in determining funding entitlement. We don't believe that victim impact statements are relevant at all in determining the issue, which is a narrow issue, of whether or not an abuse has actually occurred. We had a number of questions with respect to the funding for counselling or therapy.

Bill 100 provides for funding to be provided, but it is unclear under this mechanism how the program would be funded, how the success of therapy and counselling would be monitored, whether there would be any ceilings to the amount of funding a victim is entitled to receive or whether the funding is to be paid directly to the victim or to the therapist/counsellor.

Bill 100 provides that a victim's eligibility for funding is not affected by an appeal of the panel's finding. That is, funding for therapy would continue notwithstanding that a finding of sexual abuse made at a disciplinary hearing was being appealed. In the event that the appeal was ultimately successful, it is unclear from Bill 100 who bears the cost of continuing therapy, if there was a mechanism of the recovery of the funding paid out for the therapy or counselling where the finding on appeal does not support the allegation of sexual abuse, and from whom is funding recovered.

Bill 100 provides that funding will be reduced by any amounts required to be paid by OHIP or private insurer. We wondered what the mechanism for this would be. We wondered how this could be reconciled with confidentiality requirements under the Ontario health insurance plan and indeed with the victim's own private, contractive insurance.

Bill 100 provides that a college which provides funding for therapy or counselling has a subrogated right of action against the perpetrator. That is, the college would elect to exercise its subrogated right of action and



in essence steps into the shoes of the victim as if it were bringing the civil action instead of the victim. The victim's right to recover damages in a civil proceeding would thereby be extinguished unless the college itself elects to limit its action to the amount of funding that is provided. We had difficulty understanding how this provision, as currently drafted, would assist victims and we felt in reading it that it fundamentally disempowered victims and would compromise healing.

We believe that the vast number of health professionals desire to provide their patients with health and wellness care and appropriate treatments. We believe that resources must be allocated to the development and enhancement of education and sensitization programs.

If I could just spend a moment on this, the college had a difficult time reconciling the goal of zero tolerance with the mechanism in the legislation that would allow third-party or mandatory reports to be received by the college and kept on file. It is felt that this was not an appropriate mechanism for addressing abusers immediately upon that information being communicated to a college.

It was felt that a fair balance would be that, once a complaint of patient sexual abuse is received and information is passed on to the alleged violator, at that point a decision can be made whether it would be appropriate to refer the matter to an education program or a sensitization program rather than having it sit in the file, because we felt that this lent itself to further abuse.

We believe that there must be a sensitive and professionally administered parallel process providing an alternative to discipline which may be appropriate to be triggered at any stage, either before or after a complaint or report of sexual abuse or demeaning remarks or behaviour is received. We believe that this approach will more readily achieve the goal of zero tolerance and will minimize the risk to others at a fraction of the cost.

We felt that the gearing-up of the investigative and litigation machinery as a first recourse may be costly and unnecessary and we felt that it may be of more benefit to lawyers than to anyone else, least of all victims and survivors of unprofessional criminal behaviour.

I'd be pleased to answer any questions.

**The Chair:** Thank you very much and I regret again that I'm afraid we're within two minutes of losing our feed here, so I'm going to have to call these closings to a hold.

I say to the committee just before adjourning that we will be meeting in closed session with two witnesses who asked to meet with us in closed session beginning at 7 pm and at 7:30 we will be back here in this room to begin our hearings for this evening. Thank you again. The committee stands adjourned until 7 o'clock.

*The committee recessed at 1810.*

*The committee resumed at 1900 in closed session in committee room 2.*

*The committee resumed at 2000 in room 151.*

**The Chair:** The standing committee is back in session and we are hearing representations on Bill 100, An Act to amend the Regulated Health Professions Act, 1991.

ROBYN JOHNSON

**The Chair:** Our first witness this evening will be Robyn Johnson, if she would be good enough to come forward. I might just thank you again, Robyn, for helping us out with the time.

Just as you sit down and make yourself comfortable, for members of the committee, you've received two copies of the summary record of the testimony, and our researchers are going to provide today's tomorrow, as soon as they can have it. It may be a little rough, but I think it will still be of great help to us.

Welcome to the committee.

**Ms Robyn Johnson:** Thank you. My name's Robyn Johnson and I am a survivor. From the time of a few days old, John Minich Sr became our whole family's physician. He started my abuse with comments on how nicely I was filling out and how I grew over the summer. He was grooming me with flattery, sexual comments etc. Minich abused me from the age of 12 to the age of 17. It is difficult to explain to people who have not been a victim of sexual abuse, to express the damage and scars that are there for ever.

I look back, and 24 years ago I was carefree, trusting and open, not a care in the world, like any other 12-year-old. At age 17, his abuse became so horrific and blatant that I changed. I isolated myself. I did not trust. I felt ugly, dirty and kept asking myself, what did I do to deserve this? Unfortunately, I was in my last term of grade 12 and could not concentrate in class. I would break down crying. I spaced out a lot. Your body's there, but your mind is nowhere.

Until the abuse, I had applied to two colleges and I was accepted. Up until the abuse, I was doing well. The abuse made it so that I could not cope and I started skipping classes, wandering aimlessly, because of my lack of coping and being there in body only. I ended up two credits short of graduating from my class, with many questions, knowing I was a very good student.

My school counsellor must have called me in four times before I finally told him what happened. He knew it was something major because it went totally against my character. He told me to tell my parents, which I did, and never to go back to Minich, and he even offered me the name of a female doctor. I later found out that I was not the only one to tell the counsellor. He knew of a few more. I met them all in court.

After my experience with Minich, I went twice to a doctor in four years, at the expense of my own health. I never went to another doctor until I was pregnant and I had to. I have always avoided medical care unless it's absolutely necessary. Even though I trust my doctor now, who delivered my babies and has been very good with me, I have had one Pap smear in 12 years, only because I thought my symptoms warranted something really wrong.

Today, I suffer from severe panic attacks, agoraphobia, family problems, lack of family support because they don't understand flashbacks, the nightmares, the depression and no intimacy. I have increased migraines and general pain, knowing someone I trusted completely hurt

me and harmed me knowingly. I am only now in therapy and starting to deal with everything he did to me. I coped by blocking out a lot.

Victims do not want to be victims. They want to be survivors. I am only one of 28 women who criminally charged him and had the courage to come forward, but there are hundreds who could not come forward for different reasons, and I understand that. This doctor for 30 years, until he got caught, was abusing. His licence was revoked for one year. He received six years' jail term. He can now be paroled in one sixth of his time, and he plans to in January. This is what we call justice.

I do not want this to ever happen to anyone again. This bill has to be clear, concise and have no loopholes for the perpetrator to slip through. I will only speak to you about the issues of education and funding.

On funding: I agree that it should be a choice of therapist, but funding should also include other areas. When I was abused, I received no help anywhere. When my abuser was charged with 28 counts of sexual abuse in June 1991, there was no choice of funding available. I went to the rape crisis hotline, then eventually I had one-to-one counselling for two months with them.

Over one year later, because we were a unique group by having the same abuser, four survivors got into a support group for a 12-week session provided by the assault centre. After this, it was clear that three months of a couple of hours of therapy a week did not nearly begin to scratch the surface of the pain, the violation of my body, the breach of trust or how to deal with flashbacks or the fallout that happens in a family with someone dealing with abuse.

Unfortunately, the assault centre has had major cut-backs and does not provide these services any longer. My only choice, as a single-income household, was to stick my neck back on the chopping block and go to a doctor who was covered under OHIP.

I went to my first therapist for a year. She did more harm than good. I was ready to give up. I was depressed and totally despondent. I could not afford \$75 an hour and up for a therapist who dealt with sexual abuse who was not under OHIP, nor could I find a female psychiatrist without a huge waiting list or who is accepting new patients.

I am now in therapy with a male psychiatrist, which makes it difficult at times to go into any depth of my abuse. He is helping, but it was out of desperation and good recommendations that I took a chance with a male. He is good, and I never would have dreamed two years ago of a male doctor, so I've made some progress.

I feel the college takes too long to have these disciplinary hearings. In the meantime, the abuser is still practising. In my case, the abuser was restricted on conditions of bail not to see female patients without a nurse present. He disregarded this. He had a secretary present sometimes. With this breach of bail, he was then restricted to seeing male patients only. The college had so many complaints on this doctor, but it chose to wait until the doctor entered a guilty plea on 28 counts in criminal court before it held the disciplinary hearing.

I feel funding should be made available immediately when a complaint is filed. One to two years down the road is far too long for an abused patient to wait for therapy. I also think funding should not be exclusive to a therapist or a counsellor outside of OHIP. There's no time frame in which to heal. One hundred hours or \$10,000 is unrealistic. Again, education is needed here. Funding should be available for any specialist in the field of sexual abuse and related issues, for small groups or large groups to be able to have speakers on post-traumatic stress syndrome, self-esteem workshops, self-assertiveness courses, family counselling, workshops for partners or loved ones who are suffering living with the abused, self-defence classes etc. I was robbed of my education. To go back would be very therapeutic. This is not compensation; this is therapy which you cannot get all in one place.

I also feel that these should be offered as soon as a complaint is filed. Don't leave the victim dangling, trying to find these places of help on her own. Many times a victim is totally immobilized and does not know where to turn for help. This should be part of the education process, for the colleges to get this information and be able to direct the victim and advise them of what's out there.

## 2010

Every professional found guilty of impropriety or abuse should pay a heavy fine so funds are available. My abuser had his licence revoked for one year, no fine.

In conclusion on funding, I feel the colleges should give the funding to the patient. It takes years of therapy to heal from abuse and to regain self-esteem. A patient may decide to attend a few workshops or take a self-assertiveness course as well as therapy.

Finally, this is not compensation for pain and suffering. If a person chooses to sue civilly or go to victims' compensation, that's for pain and suffering, and the college should pay. They licensed the perpetrator; they're responsible for policing them.

Funding is a must for victims. Other than that, the college is nothing more than a paper factory, putting its signature on certificates. Zero tolerance means weeding out the bad, punishing the abuser and helping the victim. Someone has to take a stand and say, "What can we do to help you through this?" and do everything humanly possible to help. It would be nice if we could adopt some of the Jesuit fathers' recommendations on disciplinary hearings with the helping of victims.

In conclusion on funding, it would be nice if we, the survivors, did not have to revictimize ourselves by going to civil court or victims' compensation. In my brief, I have the Jesuit fathers, the way they handled discipline, okay?

Now I'd like to go on to education. Every governing body that exists under current legislation has developed a sexual abuse prevention plan, which is a very positive step. The easiest place is at the grass roots. It must be part of the curriculum for anybody going into the health care profession; not just a mere mention of the oath, but a program of what sexual abuse is and the effects the



abuse has on the victim and the family, which can only be described by a survivor of sexual abuse, by a health care professional. They need to go into post-traumatic stress syndrome—really focus upon this; this could be a complete subject unto itself—ramifications to the professional and what are appropriate questions and behaviour and what are not.

Professionals already in practice must take a course as a continuing education plan within a two-year period, mandatory, not an option; also, if told of abuse, how to handle it. In my experience, I had terrible things said to me when I had to explain why I was on certain medication. I had a doctor say: "Hey, he's a nice guy. I golf with him. He wouldn't do that." I had a technician giving me a test. She asked questions about my medications, and when I told her, her response was: "Why would he bother with patients or young girls when he could have anybody he wanted? He's a real ladies' man." I found this demeaning, and it made me feel like I wasn't believed.

Also, after the doctor pled guilty in criminal court, there were 10 doctors who had letters of recommendation stand in evidence as to his character and competency. They had a chance to pull these letters and they did not. This only reinforces the fear of the old boys' network staying together. This is why education is needed around how to listen and not to judge when the victim has the courage to disclose their abuse.

Staff education: Receiving or investigating allegations of abuse is extremely important. This can make the difference of a frightened victim going forward with a complaint and charges or being scared off by the treatment they receive from that very first phone call. The disciplinary hearing too can scare them off.

Again, I feel the survivor could be a useful person to have on the team. The survivor, as part of the team, can console and reach out to the victim who feels at the time that they're the only one out there who has ever gone up against the powerful body of any of the colleges. Also, a survivor can sometimes explain the process repeatedly, if necessary, because many times the victim finds it hard to comprehend what is being said to them by the investigator. A survivor is also a great source of information, because they have been to the hearings, they've been to court and they've laid criminal charges. We've networked and we know what's out there for the victim, what support services—and not many, believe me, not in Hamilton anyway.

We, as survivors, have had very little standing, from laying a complaint to being just a witness in criminal cases to being observers only in parole hearings. You have to give some of the power back to the survivors. The offender has all the rights. If you want victims to become survivors, then we, as survivors, should be part of the advisory committee, part of the educational process on all levels, as advocates and support for the victims going through any of the hearings or the things I mentioned above. If you want a sexual abuse plan that is going to work, you have to include survivors who have been there and know the system the best. After all, we are the experts on abuse. You could be wasting a wealth of information and help if you exclude us in the overall

fight to prevent sexual abuse.

Public education: Some areas of sexual abuse are not taught in schools or at home, and this has to change. As an example, I was told when I started my period that my body was changing and that I had a woman's body which needed regular Pap tests to check for ovarian cancer, cysts, cervical cancer etc, which my grandmother was being treated for at the time.

It was a very good scare tactic, one that worked real well with me, but logically, he was making sense to a 12-year-old. I thought my friends, my mom, everyone, was having this done, so I didn't talk about the embarrassing procedure. By the way, it wasn't a Pap test at all. I was being sexually abused. I received it, and 20 and some odd years later, I realized when I went to a doctor who was not abusive that it wasn't a Pap test. I figured all this new fandangled equipment was something new, whereas it was not; it was standard.

Twenty years later, my daughter starts her period. I panic, thinking she will have to have a Pap test. I knew she would be mortified, just as I had been, but I was going to insist on being in the room with her just to talk and keep her calm. When I mentioned this to my doctor, he was shocked and he set me straight on when you receive a Pap test. With that revelation, I knew I was abused from an earlier age than I thought.

I phoned my daughter's school—her school runs from grade 6 to 8—to see if anywhere in their curriculum they covered when to have a Pap test and what a Pap test is. She said no; they covered birth control, reproduction, VD, AIDS, but nothing about a Pap test. I was shocked. Nothing had changed in 20 years. I also look back and see the grooming process that took place, another area that the public needs educating on.

Sexual abuse and abuse should be taught at home and in the schools, not to let sexual comments go. I feel that a pamphlet could be in every health care professional's office, for example, a patients' bill of rights, and on the flip side, the doctor can have his expectations: If you miss an appointment, you pay; you're expected to be on time for appointments etc. Whatever he wants to put down, he can have his say on his side.

In conclusion, if the message you clearly want to send out to the public is zero tolerance, then revoking or suspending a licence for five years or putting conditions on an abuser who can still practice is ludicrous. Zero tolerance means revoked for life so that the oath of, "Thou shalt do no harm," is a guarantee. Have the backbone to do what you say. In my opinion, if a professional behaves like one, he will never have to worry about sexual abuse or sexual harassment. Sexual abuse is incompetence. It is showing poor judgement, and in my mind, there is no poorer judgement than abusing their patients.

## 2020

A repeat offender with more than one charge should have their licence revoked for lifetime, not just in Ontario but in our country, Canada. Why give the abuser the chance to go to another province and just pick up where he left off? Many articles I've read tell of doctors who



have had their licences revoked in Ontario and just move on to Quebec to prestigious hospitals and become head of psychiatry and continue to abuse their patients. This cannot go on.

Don't chase the offender out of your backyard into somebody else's, because they're going to repeat the abuse. If a professional leaves the country, goes to the USA, full disclosure of his conduct should be given, with a strong advisory that this person is a high-risk person, and in the interest of safety of the general public, this perpetrator is not suitable for any health care position.

A great fear of mine is that a doctor or any other health care professional can hang up his shingle as a counsellor or therapist, because they're not regulated. They can have their office with their certificate of graduation in whatever field, and reabuse the same way. Follow-up has to be maintained, however, somehow, if you truly back zero tolerance and protecting the public from future harm.

Possibly taking the courageous steps that Toronto recently took with a sexual abuser could be a precedent set for the college and police to let the public know that a sexual abuser, especially a repeat offender, is living in their community. This is truly protecting the people. The oath says, "Thou shalt do no harm," and if it is meant, zero tolerance is just what it means.

It will take a great effort on behalf of the colleges, memberships, public, education programs, institutions, professional associations, survivors, and most of all, government. This is what has to happen to be part of the solution.

Thank you for your attention and any consideration given to Bill 100 I have suggested. My speaking publicly to authority figures has been nerve-racking, but it has been a milestone in my therapy. I'd be happy to answer any questions.

**The Chair:** Thank you. We have a few questions.

**Mrs Haslam:** I just had one. I'd like to know your view on mandatory reporting. We are getting quite a number of different reports on that and I'd like to know whether you felt mandatory reporting by all professionals in the health care system should be part of this legislation.

**Ms Robyn Johnson:** Yes, I do. I think it covers it very well in that one paper I gave you on the Jesuit fathers on reporting. They can hide behind confession. If they report in confession, then it's no good.

I don't believe, when it comes to the health care profession, that you should be able to hide behind anything. I think mandatory reporting should be just that. If the patient is not willing to come forward with their name, because they're afraid to go one on one with the doctor, that's fine. Report the doctor, wait for a second or a third name and then that first person, I would bet you, would come forward; they would.

**Mrs Haslam:** I know other people have questions. I'll pass at this time.

**The Chair:** You can have a supplementary on that, if you want.

**Mrs Haslam:** No, my only other question was around the wording. There's been some discussion around words and behaviour, around reporting that also. I didn't know if you had an opinion on that also, versus touching. There's also a clause around reporting of the words and behaviour, not just—

**Ms Robyn Johnson:** To me, it's all sexual abuse. If you can understand it as a grooming process—that's how it started with me: "My, you look nice. My, you're filling out nicely." It is a grooming process. If you've got a doctor who's doing that, believe me, down the road, it's going to go further. So yes, it's abuse. I don't think it should be defined as harassment, I don't think it should be defined as misconduct; it should be defined as sexual abuse.

**Mrs Sullivan:** You've left with us quite an impressive package here. You've put a lot of work into preparation for your appearance here. I notice that in one section you've done a draft of ideal components, from your point of view, of a sexual abuse plan for a college, and one of the items that you've included are guidelines for professional behaviour.

What we're told by different colleges is that each one has a different scope of practice and that members of one college may not particularly know what another college would be doing or would be allowed to do within its scope of practice, what's appropriate to do in clinical terms.

One of the things that you speak about here is the establishment of guidelines to delineate appropriate standards of behaviour within the patient-practitioner relationship. It struck me that if one was reporting within one's own college, with those kinds of guidelines available that had been established and distributed, one could be fairly sure that one's observations were appropriate. However, with respect to another college, it may be more difficult. I wonder if you'd have some comment on that.

**Ms Robyn Johnson:** Perhaps you could give me an example of, let's say, one of the colleges, something that you would think might not be appropriate.

**Mrs Sullivan:** I'll describe a problem that was put to me. A member of the physiotherapists, by example, in the course of fitting a device, an artificial leg, had to move the genitalia of a man. Someone else observing that may conclude that it was sexual touching, not necessary to the practice, because of the way it was done or whatever, and report what in fact was very much a part of that procedure and necessary to the proper fitting of an artificial leg, or the limb. Someone who was also a physiotherapist may well recognize that the method was quite appropriate and well within the bounds of the clinical practice.

**Ms Robyn Johnson:** I think it depends on the patient, what preceded the touching of the genitalia. If the patient was threatened and if the patient made a report to the college and the college deemed it appropriate, then that patient—

**Mrs Sullivan:** That's where the problem is. It's not the patient who's reporting; it's a third party who's doing the reporting, somebody from another profession.

**Ms Robyn Johnson:** That's why you have a disciplin-

ary hearing. But I truly believe that when you've got different races, different religions, different people to whom some things may be offensive, you have to take that into consideration, because a male may feel very uncomfortable having his genitalia touched when he could have moved it himself and had the same procedure done. It's a matter of how you approach the patient, how the patient perceives it.

Like I say, it may go to the college and have no substance at all, but then again it may. It depends on what happened before, what was said. Every situation is different. I can't just judge on one example.

If I had a podiatrist looking at my feet and all of a sudden he started rubbing my leg and moving up my leg, I would know that's wrong. A podiatrist is supposed to be looking after my feet. But somebody else looking on may say, "Well, I'm checking the muscle structure, I'm checking the tendons that go into the feet." It could be perceived as perfectly normal, whereas to a patient it could be very sexual.

2030

**Mr Jim Wilson:** Ms Johnson, thank you very much for showing us your courage and coming forward and telling us your story.

You mention on page 4 of the typed portion of your brief some of the services that you think should be offered; for example, family counselling, workshops for partners or loved ones who are suffering living with the abused. You say, "I also feel that these should be offered as soon as a complaint is filed."

My question is, under our system, whether it be in the college disciplinary system or our regular justice system, the problem with offering services to a victim early on in the process is that we do have the presumption of innocence until the alleged abuser is found guilty of that. So perhaps in answering my question, you could tell us a bit more about what your experience was with the college and why you feel these services should be up front.

**Ms Robyn Johnson:** By the time the disciplinary committee gets around to having the hearing, you can be looking at two years. Two years is too long to leave a victim dangling. So many times they're immobilized. They don't even know how to network, how to reach out and find other survivors. I feel that if you get them the counselling immediately, and then further down the road, in two years, if the doctor, let's say, is found innocent, then you can be looking at retribution. In the meantime, if you've got a real victim there, a victim can't wait two years.

I had to wait. I had to wait until the criminal courts—he pled guilty before the college made any attempt at the hearing. The hearing could have been done much sooner. He was charged. He had 28 criminal counts. He had umpteen dozen complaints laid at the college, way more than 28. They had enough to move on, but they didn't. They waited for that guilty plea.

Fortunately, my disciplinary hearing was wham, bam, in, out, three minutes and that was it. He wasn't even there. His lawyer pled guilty, but that was two years

down the road, and that's too long. In two years down the road you could have a victim commit suicide, have their family break up. I'm giving you extremes, but believe me, a victim doesn't know whether they're coming or going when this first happens. It's devastating. It takes over their life.

**The Chair:** Ms Johnson, thank you very much for coming before the committee and for your presentation, and also for the documents that you've left with us.

JEAN HALLIWELL

**The Chair:** If I could call our next witness, Miss Jean Halliwell. Miss Halliwell, welcome to the committee. Have a glass of water and please make yourself comfortable. When you're ready, go ahead.

**Ms Jean Halliwell:** You'll have to forgive me for the water. I've got laryngitis, so I'm going to talk very carefully, hoping you can hear me.

My name is Jean Halliwell and I'm from London, Ontario. I am a victim of sexual abuse, and although the abuse happened in the mid-1970s, I am still being victimized, not by the psychiatrist but by a system that thinks, as a woman, I don't matter. As an ex-psychiatric patient, my credibility is questionable.

If these sound like strong words, they are meant to be. If we as adults find it so hard to be heard and to be believed, how can we expect children who are abused to be treated fairly in this double-standard society?

Ladies and gentlemen, let me tell you a story.

A young family came to Canada from England in 1967—husband, wife and two children. The wife did not really want to come to Canada but she tried to make the best of it. After being in Canada a short while she developed a phobia, a phobia which in the next year or so threatened her peace of mind so severely that she decided she needed to see a psychiatrist to find out what was wrong with her. She knew she needed help. She received help, all right.

The psychiatrist eventually sent this lady to see another psychiatrist who specialized in biofeedback. From that time on she was under the sole care of the second psychiatrist. During this time the psychiatrist tried a new course of treatment: injections of Ritalin and sodium Amytal injected simultaneously in a vein in her arm. It was during one of these drug therapy sessions that the doctor told the patient he was going to try something new. It would help her and she was to trust him.

He proceeded to partially undress her and himself. At that point the patient noticed a cast on the doctor's leg going up almost to his groin. He had broken his leg a couple of weeks previously. He proceeded to have sexual intercourse with the patient.

The effect that these two drugs have on you is very strange. Your heart races, you feel euphoric and you are very aware of everything that is happening, but for some reason you have no way of exerting your own will. In this altered state your brain does not seem able to allow you to judge whether what is happening is right or wrong. In a drug-free situation she knew this kind of behaviour could not or would not have been allowed to happen without a fight.



For the next three to four months, on Tuesday and Thursday afternoons, the injections were given. Abuse occurred; sometimes intercourse; sometimes oral sex was demanded of the patient. The psychiatrist never touched the patient in a sexual manner, only when she was under the influence of these drugs.

The patient, on leaving his office after these episodes, immediately buried the information. During this period of the patient's life, because she was being forced to deal with issues and feelings that caused her a great deal of pain, she was in a vulnerable position, and this doctor, knowing this, took advantage of this situation—which, the way she sees it, makes him a despicable human being and a criminal.

The patient told her husband about the abuse during the time of the abuse. The doctor's comments to the husband were: "She's emotional. She is sick. Some patients fantasize these things with their doctors." The doctor immediately reprimanded the patient, telling her he was trying to help her get well and how ungrateful she was and how it would be too bad if she ended up in the London Psychiatric Hospital and lost her children. The threat worked. She didn't talk about it again and for a short while the abuse continued. Over a period of the next three to four years the patient's medications were increased to a point that she hardly knew one day from another.

To cut a long story short, she finally got the courage to stop seeing the doctor, and by then the knowledge of the abuse had been buried so deep it was as if it had never happened, until a simple thing like a TV movie triggered the memories and it all came flooding back.

Her next step was to ask her family doctor for help. She told him about the abuse. He was sympathetic but was of no other help. A little later she talked with someone at the College of Physicians and Surgeons and was told that because the doctor was no longer practising in Ontario and because "you are only one complainant," the chances of doing an investigation were very slim.

2040

On talking to the London police department, she was told the statute of limitations had gone by and "with you being only one," there isn't really much they could do. Her husband, her family doctor, the College of Physicians and Surgeons and the police department all felt she was not important enough to validate what happened to her.

What is my point? The point is, ladies and gentlemen, that as a victim I speak from experience of the pain that is inflicted on someone who has been abused by a health professional. I speak from experience why I think Bill 100 is useless unless you include mandatory reporting. Sexual abuse by anyone is an abuse of power and is wrong, but today we are dealing specifically with abuse by health professionals.

I am sure you are finding it hard to believe that I could be a victim. Today you would be right. In the 1970s, yes, I was scared. I was vulnerable. I was naïve. It is then that physicians who abuse take advantage of patients.

No one—and I repeat, no one—is immune from possible abuse. Whenever you or a member of your

family walks into a doctor's office, you are troubled in some way. You may have symptoms of an illness. You may have lost a loved one. You may have marital problems. The stress in your life is causing too many headaches. Whatever the reason for your visit, you have been conditioned to trust your health care professionals. When we go into the sanctuary of a doctor's office, we can hope in our hearts and tell this person how we hurt. If we don't, then he cannot help us to heal.

At that point you become vulnerable. The balance of power shifts. If the doctor is one of those bad apples, he will then pry more information from you so that he can ascertain just which way he needs to go to satisfy his own urges.

Gentlemen, you needn't feel complacent. Yes, the chances of your being sexually assaulted by a male physician are remote, but I am sure there is someone in your life whom you care for deeply, maybe your wife, maybe your daughter, maybe your sister or your mother, maybe all of these, and if only for these people, you have to take mandatory reporting seriously.

The OMA is a lobbying group with a lot of influence. They represent a group of citizens who are well educated, their financial standards are one of the highest, and as a result can afford to have good legal advice telling them the best way to get government to listen to them so they can protect their interests. We, as victims, have none of these opportunities.

We come to you one at a time without benefit of legal counsel, just like a small ant trying to move a mountain. And as we are so small, too insignificant, we are usually ignored. But please take heed: We too can become a lobby group of enormous power; if not with money, with sheer numbers.

Our state-of-the-art medical care is in trouble, which means we are cutting services to cut costs. Sexual assault victims cost the taxpayers of Ontario millions of dollars a year. You see, the trauma of sexual assault, especially if the person is not able to deal with the abuse, will manifest itself in other ways. Your physical symptoms begin to emerge, starting a circle of visits to specialists, tests, procedures and even surgery, not just once, but over and over again, which, when multiplied, cause an enormous drain on our health care system. Plus the fact that doctors who abuse charge OHIP for the privilege of abusing their patients. The abuse usually occurs in the doctor's office and the secretary has made your visit a chargeable one.

We are either part of the solution or we are part of the problem. Mandatory reporting will mean you intend to be part of the solution. Leave that out of Bill 100 and you become part of the problem. You will send a clear message to our health care professionals that: "Government is on your side. If you happen to abuse your patients, so what? They're only women and children."

Physicians in Ontario fear mandatory reporting. I wonder why? Their excuse is it could become a witchhunt. This is a smokescreen. The loyalty doctors have for their colleagues is admirable, but it is misplaced. The loyalty should be with their patients. If a doctor has to make a choice of loyalty to a patient or one of his



colleagues whom he respects for his talents, his choice is usually the doctor. There is always another patient. The colleague spent years perfecting his skills. Why would he jeopardize his livelihood? It cannot be possible.

The problem is that physicians who abuse are clever and calculating and gain the trust of their colleagues in such a way as to make it almost impossible to believe that they could do such a thing, whereas a doctor always sees a patient's weaknesses. He hardly ever sees them when they are strong and healthy, only when weak or ill. But behind closed doors, with no one else present, this fine, upstanding doctor can abuse knowing that of the two of them the public will believe him before they believe the patient. Why? If the public were to believe the victim, then they too have to look at their own vulnerability and recognize the fact that no one is immune behind those closed doors, and that is something not many people are willing to risk.

Doctors are human beings, with the same urges, weaknesses, strengths as the rest of us and subject to the same stresses. Male doctors are no different than the man in the street. They too can be turned on by the sight of a female, dressed or undressed, and if his private life is less than perfect or his stress level has reached gigantic proportions, his judgement can become just as impaired as the man in the street's. If he decides to cross the line because of his dissatisfaction, it will become a pattern that whenever he's under stress he acts out that stress with his patients.

Mandatory reporting will weed out some of these people—not all. This is just a first step in addressing a problem that has to stop. Female doctors I have spoken with have no problem with mandatory reporting; only male doctors seem to be concerned. If you are ethical, caring and non-judgemental, no patient is going to jeopardize losing you as their doctor by laying false charges of sexual misconduct. This so-called witchhunt is a self-serving tactic to keep the status quo, to keep patients silent and to keep the power they have learned to accept, and in some cases demand.

2050

Everyone is accountable for his or her actions. Physicians should be no different. If you do something wrong, you should be made to pay the consequences. If a doctor abuses—it may not be today, it may not be tomorrow; it may be next year or maybe 20 years from today—there should be a system in place where a patient can go to report what happened to them.

Victims can only start to heal when they are able to vocalize, and that can take years. If the abuser happens to be a health care professional, they have more reason to delay asking for help. We as victims need to be treated with the same respect that health professionals demand. We as victims crying in the dark need for you to recognize that by not feeling our pain, not listening to our single voices, we have no value, that we, like ants, can be trampled underfoot.

The western world vowed after the Second World War we would not allow another Hitler to be spawned, but in order to do that we sometimes have to resort to dictatorship methods to stop that from happening. We in Ontario

are facing a dilemma on whether to dictate to the health care professionals something they should have been willing to do on their own on ethical grounds. If they were willing to accept that kind of responsibility, it would have been in place by now.

Before I went public I personally mentioned about my abuse to at least 11 doctors. No help was offered. Sometimes legislation is the only way we can be sure changes are made. Sexual abuse of our women and children is of epidemic proportions. By taking a mandatory reporting stand, you are sending a clear message to the rest of Canada that Ontario is a leader in respect of individual human rights and will not allow one segment of the population to abuse another segment of the population.

Bill 100 will transcend even your term in office. It is not a panacea. It is not the answer. It won't stop health care professionals from abusing. It is the first step by the government of Ontario to recognize its responsibility to the people who helped put it in office. Please do not allow the medical profession to seduce you into watering down this bill so that it becomes ineffective. Neither allow it to pass so that it can be successfully challenged in the court system by large lobby groups with very deep pockets. Make it effective. Make it work. Let the citizens of Ontario know that you are willing to take the first step towards zero tolerance of sex abuse by the health care professionals in this province.

The first step down a long road is usually the hardest, but you will go down in the history of Canada as being the first to recognize that violations of individual rights and freedoms to our person while under a health professional's care will not be tolerated, therefore taking that valuable first step.

Ladies and gentlemen, it was important for me to be here today. I thank you for your patience. I hope it was not in vain.

**The Chair:** Ms Halliwell, I don't think that anyone could have put their case more eloquently than you have this evening. Despite the laryngitis, we're glad that you were able to come to speak to us. I know we have some time for questions but, quite frankly, the message that you read was very overpowering. I don't know if there are any questions. Rather, the members just need to think about what you have said. We thank you very much for coming this evening.

**Ms Halliwell:** Thank you very much. If I can't speak for the next week, it was worth it.

#### ONTARIO SOCIETY OF OCCUPATIONAL THERAPISTS

**The Chair:** I would then call upon our next presenters, the representatives from the Ontario Society of Occupational Therapists, if they would be good enough to come forward. Help yourself to some water, if there's still some water and glasses there. We can get some more. I apologize that at the end of the day I'm afraid we've fallen behind, but we appreciate that you have stuck with us and are here to make your presentation. Please go ahead and introduce the members of your delegation and then begin your presentation.

**Ms Debbie Cameron:** I'd like to begin by thanking

you for the opportunity to come and present before you tonight. I'll just begin by introducing ourselves. My name is Debbie Cameron and I'm the vice-president of the government affairs division of the Ontario Society of Occupational Therapists. To my left is Christie Brenchley; she's an occupational therapist as well and our executive director. To my right is Mary Kita; she is the co-chair of our RHPA task force and a senior occupational therapist at Riverdale Hospital here in Toronto.

The society is pleased to have this opportunity to respond to Bill 100, An Act to amend the Regulated Health Professions Act, 1991. There are currently over 2,400 occupational therapists in the province of Ontario employed in a variety of settings including, but not limited to, hospitals, treatment centres, schools, community and private practice. We work with clients of all ages whose lives have been disrupted by physical injury, illness, the aging process, congenital-development disabilities or social and emotional problems.

Occupational therapy is client-centred and focuses on facilitating the achievement of the client's personal goals. We also focus on maximizing functional performance in the areas of self-care, productivity and leisure and enhancing a person's ability to live independently in their community.

The Ontario Society of Occupational Therapists firmly believes that sexual abuse of clients by any health professional is never acceptable and must not be tolerated. We do, however, recognize that sexual abuse by health professionals occurs. We, as occupational therapists, join with the general public in its concern about this issue. We believe that all health professions have a responsibility to educate their members, promote the prevention of sexual abuse and comply with all legal requirements. As occupational therapists and professionals, our members do not wish to practise alongside of others who commit offences of this nature.

We'd like to begin by stating that the society strongly supports the consensus recommendations of the Ad Hoc Coalition of Regulated Healthcare Associations. This group's aim from the beginning has been to work alongside the Ministry of Health and other interested parties—survivors' groups and regulatory bodies—to ensure that the legislation is effective and efficient and protects the interests of both the consumers of health care and the professionals.

The recommended changes to Bill 100 and their rationale has already been clearly discussed in great detail by the coalition. Therefore at this time we will only state that we support the coalition's position in all areas, including definition of sexual abuse, mandatory reporting by professionals, the therapy and counselling fund, intervenor status and the grafting of Bill 100 onto the RHPA.

The reason that we made the decision to present here tonight was to lend breadth to the coalition position and also to represent a small female-dominated profession. Therefore, we would like to utilize our time here tonight to discuss specific issues which concern us directly as occupational therapists. Our concerns fall under four major categories: the potential impact of Bill 100 on the

therapeutic relationship, the definition of sexual abuse, the therapy and counselling fund and the nature of our profession.

There are many instances in which our practice includes touching of sensitive areas and discussions of sexuality. As part of our assessment and intervention, we explore with clients their functioning in their daily lives and roles. These roles may run the gamut from dressing and toileting skills to vocational rehabilitation.

## 2100

Depending on the individual circumstance, their roles as sexual beings may be discussed. An occupational therapist may frequently need to touch a client during a treatment session, for example, while fabricating an orthotic, facilitating movement of a limb, teaching a life skill or transferring a client from bed to wheelchair. Therapists may also utilize touch to provide comfort, support and encouragement.

As occupational therapists, much of the successful outcome of our treatment depends on our ability to develop a strong therapeutic relationship with our clients. This relationship is based upon open lines of communication and trust, and it is vitally important to both therapists and their clients that this relationship remain a strong one.

An outside observer may view legitimate treatment activities as inappropriate or not within the scope of occupational therapy practice and thus reportable offences. Furthermore, therapists who fear that their actions could be misconstrued may withdraw slightly from a therapeutic relationship and limit their interventions. Literature on sexuality frequently states that clients already feel that sexuality is not adequately addressed, particularly during the rehabilitation process.

I just wanted to draw one example which Mary brought to my attention from her particular practice at Riverdale. There was a gentleman who had suffered a stroke and had been in Riverdale for quite a period of time. He was due to go home for his first weekend leave with the family. The team felt that they had adequately addressed every issue that could possibly come up. They'd investigated the bathroom and put in grab bars. They'd figured out how the client could get home and what transportation would be involved. They thought they had covered all the bases.

They couldn't understand his growing concern about going home for the weekend. Finally, with much prodding, he admitted that what he was really concerned about was the fact that he would be sleeping in the same bed with his wife for the first time since his stroke. He had no idea about how to deal with that situation. This is the type of situation in which an occupational therapist may need to discuss sexuality. It's a necessity that it be discussed with clients in that sort of situation.

Our feeling is that Bill 100, as currently written, may act to distance therapists from their clients and inhibit strong therapeutic relationships. Therapists would be hindered not only in their ability to do their jobs to the best of their ability, but even more importantly, our clients would not be well served.



The next issue that we'd like to talk about is the therapy and counselling fund. Traditionally, the role of colleges has been to encourage ethical and professional conduct and to ensure that those persons found guilty of misconduct are penalized. The proposed request that colleges administer a therapy and counselling fund is an additional responsibility. We are very concerned with the conflict-of-interest situation that this places the colleges in. Colleges should not be responsible for dispensing funds which can only be accessed upon a finding of guilt. As suggested by the coalition, we feel that the responsibility of administering the fund should be given to a third party, as is done currently with the criminal compensation fund.

If the fund should proceed as outlined currently, we are concerned with the financial burden that this places on our members. Occupational therapy is a newly regulated, small profession and as such will be struggling to meet the initial startup costs of regulation. As professionals, we eagerly accept the high cost of self-regulation, but do not believe that the burden should be onerous on our members.

The Ontario Society of Occupational Therapists supports the fact that sexual abuse of clients is intolerable. However, it is also important that members accused of abuse are not unduly victimized. A single all-encompassing charge of sexual abuse as currently outlined in Bill 100 creates the potential for serious harm to a health professional's career, family and entire life by the act of laying a charge. Regardless of guilt or innocence, or severity of the abuse, the health professional will be charged with sexual abuse.

In the minds of the public, they will automatically be assumed to have seriously violated a client; ie transgression or intercourse. The overwhelming impact of having a charge laid, regardless of outcome, cannot be underestimated. We recognize that it is impossible to ensure that only guilty members are charged, but steps must be taken to ensure that the charge laid is appropriate to the suspected abuse.

For this reason, as well as others outlined in the coalition response, we support the recommendation that the definition of sexual abuse encompass three categories rather than the only one as currently written.

We would urge you to consider the impact of Bill 100 on each of the professions regulated under the bill. These professions vary greatly in many ways, including salary, size, gender proportions, personal contact with the public and incidence of sexual abuse. Occupational therapy, for example, has approximately 2,500 members in the province, is 97% female, has a relatively low salary scale and little documented history of sexual abuse of clients. It is important to recognize that all of the research and knowledge gathered to date regarding this issue pertains to a very small number of professions. As occupational therapists, we recognize the severity of the problem and we accept our responsibility for our part in it. We feel, however, that changes to Bill 100 are essential if it is to be fair and equitable to not only the public and survivors but to each one of the regulated health care professions.

In summary, the Ontario Society of Occupational

Therapists strongly supports the recommendations as made by the ad hoc coalition of health care associations. We also strongly support the intent of Bill 100 but do not feel that the act as currently outlined will meet the stated intent to the satisfaction of either the public, the professionals or the survivors.

**Ms Haeck:** Thank you for your presentation. You mentioned the therapy and counselling fund and you answered at least one part of my question, giving me an idea of the makeup of your organization, that it is 97% female and in all likelihood has never had to deal with this particular issue by having someone charged with sexual abuse. You're nodding, so I suspect that you're saying yes, you've never encountered that particular issue.

I understand your concern around the funding mechanism and that as a small organization, newly regulated, you may feel that somehow where there is a possibility in some of the other professions where there has been more abuse you would be paying for them in essence. But have you given any consideration to possibly pooling with some of the other newly regulated professions which might have some similar concerns as you do?

**Ms Cameron:** If I could just answer that question, I'd say that with us representing the professional association, we won't be involved in terms of the fund. That would be our college's responsibility. We were speaking more about our concerns about the fund rather than the colleges' concerns, and I'm not sure whether they have looked into the pooling of resources at this point.

**Ms Haeck:** In all likelihood, since in the previous two years you have not had a charge laid against one of your members, and that history is outlined in the bill, you would only be required to keep \$10,000 in the fund. Would you believe that to be an onerous situation?

**Ms Cameron:** I'm not sure that I would consider the \$10,000 to be particularly onerous at this point in time, but I do think it's important to consider the other attendant costs that would go along with having a fund of that nature. I think that although we haven't looked into it in depth, there are a lot of administrative costs that would go into setting up a fund; there would probably be a lot of legal costs in terms of ensuring that the fund was properly administered. I think having that \$10,000 set aside is obviously workable even for a small organization, but the attendant costs in terms of the extra workload for the college and legal costs and administration costs may make that figure a lot higher than the \$10,000.

**Ms Haeck:** I hope we can minimize those attendant costs, because I have a suspicion they may not be quite as onerous, but then I'm making a supposition here.

Do I have any more time, Mr Chair?

**The Chair:** You have time for one final question.

2110

**Ms Haeck:** You have come at a time where you've just heard some very impassioned words and ones which obviously have swayed me and, I'm quite sure, other people, because they were very heartfelt from very awful experiences.



You mentioned that you feel the whole mandatory reporting mechanism should be changed. I have to say to you, after listening to the previous presenter, that I would feel that mandatory reporting is absolutely essential even for verbal remarks, and other victims who are sitting behind you feel the same way. Why would you, say, even speaking personally, feel that it would not be a requirement?

**Ms Cameron:** I think that's a very good point and I agree with your initial comments about the opportunity to hear some of the survivors and how that's impacted. We had that opportunity as well in some joint meetings that we've attended over the last few months, and certainly from a personal perspective I found that very valuable. It was very important to hear it from their perspective, something we hadn't had the opportunity to hear before.

I think there are quite a few reasons outlined in the coalition position and I won't try to encompass all of them. I guess, from my personal perspective, the reason that sways me the most is that experiences shown in other jurisdictions, and Minnesota is the one that was quoted in the coalition response, where they have similar mandatory reporting that encompasses that entire range, from words and gestures through to the other, since they have put that into place the amount of reports has decreased. In other words, instead of increasing the amount of reports coming from people, the reports have decreased.

I'm not saying that's a good thing, I'm not saying that reflects well on the professionals involved, but I'm saying that if a system isn't seen to be fair and equitable by the professionals it's regulating, then they will not comply with that system. I think you can even go so far as to say they will not buy into the system as a whole instead of just to that one small part. I feel that the risk that you're taking in allowing mandatory reporting for all of those things will not get the benefit which we would like to see happen, which is more reporting of damaging behaviour.

To follow further on that, I think it's important to note that the coalition position around mandatory reporting was not that those words and gestures could not be reported. That was an option that was suggested, but what was suggested was a duty to intervene where a range of options was available. So persons witnessing something that they were a little bit unsure about or weren't quite sure what was happening could take the step of approaching the person and educating the person and letting him or her know that perhaps their words and gestures, while not meant that way perhaps, may well have been meant that way but may not have and educate them about how that came across to another professional and take that step. The other options would be to meet with the clients involved and tell them that they had the option of reporting it to the college.

I don't think that our position is that we don't believe in mandatory reporting. I think we want a workable situation, and we don't believe that will be workable for the survivors.

**The Chair:** Thank you. I'm afraid we'll have to move on. On behalf of the committee, I thank you all for coming this evening and for your presentation.

#### COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

**The Chair:** If I could then call upon the representatives from the College of Physicians and Surgeons, I welcome you to the committee and also apologize for the hour. We have an oral presentation which has been distributed, as well as the other recommendations which you have made. Once you're settled, if you would be good enough to introduce those who are at the table, then please go ahead.

**Dr Joe Homer:** It's my privilege to introduce the representatives from the college. Allow me to introduce myself first. My name is Dr Joe Homer. I'm the past chair of the college's legal and internal change committee, which produces most of the college's sexual abuse recommendations. I currently chair the college's ad hoc committee on Bill 100. With me to my immediate right is Dr Rachel Edney, who is the current chair of the college's patient relations committee. She is the immediate past president of the college and is a past member of the sexual abuse task force. To her right is Ms Judie McSkimmings, a sexual abuse counsellor who is also a current public member of our council and is a member of the discipline committee of the council. To the far right is Dr Michael Dixon, the registrar of the college.

We appreciate the lateness of the hour and how tired you must be by now. You have received advance copies of our written submission. Tonight we will touch just briefly on key issues so that you may use the bulk of the time for further discussion with us.

I will start by recommending the submission made by the coalition of colleges and transitional councils to the committee. The College of Physicians and Surgeons of Ontario participated in that group and we support its recommendations.

The CPSO also supports much of Bill 100. It reflects many of the recommendations the college asked for to help our ongoing reform process. But there are several areas where serious problems will occur if amendments are not made now. I would ask Dr Edney to carry on, to begin to highlight some of these problematic areas.

**Dr Rachel Edney:** The success of this entire bill rests on whether or not we get the definition of "sexual abuse" right. To be right requires that it be clearly understood by the public and the profession, that it be enforceable and that it allow for the successful prosecution of wrongdoing. An unclear definition, coupled as it is with mandatory reporting, will undermine the college's ability to encourage the profession to accept mandatory reporting of sexual abuse. The definition must also work for 24 different professions.

The current definition does not meet those needs, nor do the proposed amendments. Many remarks or touching actions could be considered of a sexual nature, but they may also be totally appropriate and clinically required for quality health care. The intimate examination of genitalia or detailed questions regarding sexual practices are good examples.

If doctors are unclear about the offence, they will also be unclear about reporting it. The result will be that they

do not report or, alternatively, that they report anything and everything and bury investigators in a flood of paper.

Definitions that ask doctors to judge harm to a patient or determine what demeaning is call for an opinion which the practitioner may be unable to provide. It is also irrelevant. The important criterion is to determine acceptable or unacceptable behaviour. Definitions that are based on exploitation require a very subjective assessment and become extremely difficult to prosecute.

We strongly support the definition put forward by the coalition of colleges. It requested that a new subsection be added to section 3 of Bill 100. It would state: "For the purposes of subsection (3), 'sexual nature' does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided." We believe this meets the criteria and the needs of the legislation as much as any definition can.

The college introduced mandatory reporting of offences involving sexual acts and sexual touching in March 1992. We opposed it for sexual abuse offences involving words and gestures as defined in Bill 100. The category is highly suggestive and could result in so many reports that it would be very difficult to determine which ones signalled serious problems and which were the result of misunderstandings.

If this is to be reported on a mandatory basis, we believe it will only work with an appropriate definition, as outlined, and as long as colleges have flexibility to respond appropriately. If the recommended definition is adopted, the college accepts mandatory reporting of the third category.

The ministry's concept of assessment and remediation appears designed to provide this flexibility. Without detailed wording, it's difficult to judge, but as described, it should allow colleges to determine the nature of the problem. However, if remediation is to work effectively, colleges must have the ability to require that it be completed successfully by the practitioners. Otherwise, survivors rightly will see this as a way to protect practitioners from the process.

2120

**Ms Judie McSkimmings:** We're also seriously concerned that the government intends to limit patients' access to information about doctors found guilty of offences. Findings of the college's discipline committee are now available to the public, covered by the media and regularly published. There is no arbitrary time restriction. But under the RHPA and Bill 100 there will be a cutoff period after which public information is to be removed from the public register. Not only is it impossible to do, but it will not serve the public interest. Why is the ministry proposing further information be added to the register, yet asking that new restrictions be placed on the public's right to access this information? Surely the intent of a public register is to provide patients with the information and let them decide what is relevant.

Intervenor status is a difficult issue. Discipline hearings are by their nature legalistic and dispassionate processes designed to determine the guilt or innocence of the accused. It is not surprising that survivors with genuine

emotional needs as a result of abuse find this process wanting.

We believe the ministry has reached an appropriate balance in the legislation between respecting the needs of survivors to participate in the proceeding and opening up new grounds for appeal. The college will continue its efforts, as described in our brief, to provide other effective ways to include complainants in the process.

**Dr Michael Dixon:** Subject to our comments, we support mandatory reporting for sexual abuse within and across the professions. We also believe these reports must be forthcoming even if the patient does not consent to the inclusion of his or her name in the report. If the college is to effectively deal with sexual abuse, it must have the information necessary to do the job.

The college may not be able to act on a single report, but coupled with others or with complaints, the information is very useful. It should be noted that the college has strict procedural rules to protect patients' confidentiality and the rights of doctors about whom reports are made.

We also believe the treating professional must report as well. He or she has no way of really knowing whether one patient or 10 patients have been abused by the practitioner-patient. If we have the information, we may be able to assess if other patients are at risk. The college has established procedures for receipt of these reports to minimize as much as possible disincentives to seek treatment.

The college supports the ministry's proposal to remove mandatory reporting of incompetence, misconduct and incapacity across the professions. Because of the diversity in professional standards for 24 different practitioners, it would have been unworkable.

Mandatory reporting of serious incompetence may well work within each profession, but at this time the RHPA only provides the college with inadequate powers to deal with this information. The only alternative is discipline, a process often totally inappropriate for these problems. A more effective response would be to review or assess the doctor's clinical ability and require that appropriate remedial education or other upgrading be successfully completed.

**Dr Homer:** Our final and most serious concern is the proposed funding scheme for therapy and counselling. Unfortunately, we've concluded that it does not answer the needs of survivors, and may indeed put them at further risk. It will undermine professional cooperation and support for Bill 100, and it will risk the entire RHPA regulatory structure. The college is fundamentally opposed to this proposal in its present form.

We acknowledge that survivors need therapy and many need assistance to obtain it. We are prepared, under Bill 100, to obtain moneys for this goal, but we do not wish to participate in such a problematic scheme.

Professional groups and regulatory colleges believe the fund penalizes the innocent as well as the guilty practitioner, that it provides restitution, which we feel is an inappropriate role for a regulatory college, and that the smaller colleges may well go bankrupt trying to fund it. We believe that it places colleges in a conflict-of-interest



position.

Even survivors are concerned. Money will only go to a small percentage of victims, those who have been abused by a regulated health care practitioner. Survivors are eligible only after a long period of involvement with the complaints and discipline process. It provides no assessment of need; a victim of rape gets the same amount of money as the victim of a lewd remark.

Of further concern is that the proposal puts vulnerable survivors at further risk by funding unregulated therapists. We recognize that there are many well-qualified therapists who do not belong to a regulated health care profession, and we believe that patients have the right to choose their treatment or practitioner. But it is also true that there are unregulated therapists who do not have sufficient qualifications or training. In fact, some are former doctors who have had their licences revoked for sexual abuse.

In this scheme as proposed in Bill 100, there is no valid mechanism to protect survivors. Colleges will not be able to determine if a therapist has at any time or in any other jurisdiction been found guilty of sexual abuse. There is no body to consult; there are no records retained on unregulated therapists. Furthermore, information on the college's public register will be removed after an arbitrary time limit, according to the present form of Bill 100.

Further, requesting the therapist and survivor to sign a paper outlining the therapist's qualifications does not provide, in our judgement, an effective way to determine if the qualifications claimed do in fact exist.

Asking a survivor to sign another document acknowledging that he or she is aware the unregulated therapist is not subject to professional discipline is reminiscent of the philosophy "Let the buyer beware." Such a concept is inconsistent with the public accountability so desired and required under the RHPA. It will only serve to give survivors a false sense of security about the therapists they have chosen. Where are the survivors to go if they are abused further by unregulated therapists? There is no regulatory body to complain to and no college to remove that person from practice.

**Dr Dixon:** If the fund is imposed as currently proposed, we will of course obey the law. But we do not wish to be party to requirements which will in effect place vulnerable patients at further risk.

The college will not be in a position to provide any assurances to survivors as to the background, conduct or qualifications of the therapist other than what information may be allowed on our own public register. We will have to advise survivors of our inability to do this.

We urgently urge the government to postpone implementation of the fund until appropriate alternatives are found. Many have been suggested to this committee.

We recommend another alternative as well: Use the moneys provided by colleges to expand or enhance existing sexual abuse counselling services across the province. In that way, survivors will be able to readily access therapy from the practitioner of their choice, with some assurance of accountability for that person's

conduct.

Mr Chairman, there are many positive and worthwhile objectives in Bill 100 which this college wishes implemented. However, we urge the government not to jeopardize this progress. We urge that these concerns be addressed.

**The Chair:** Thank you very much. We will begin questioning. Mrs Haslam.

**Mrs Haslam:** On page 6, around assessment and remediation, you're talking about the fact that without detailed wording, it's difficult to judge. You're saying the college should have the right to make recommendations and assessments of what they're doing. What happens if those doctors don't take the courses? What options are open to you now as a college?

**Dr Dixon:** At the present time we are in a position where we can urge our members who are found to lack clinical skills to voluntarily undertake remedial action or to limit their practice. But unless we have some objective evidence that we can present before a discipline hearing which demonstrates substandard practice, in essence we can do nothing. That is one of the major shortfalls of the Regulated Health Professions Act, that whereas it provides the mechanism for physicians to be assessed by the college, there is no provision which will require further intervention in the form of education or remediation or further assessment.

2130

**Mr Jim Wilson:** Just a quick question with respect to your liability in relation to unregulated practitioners: I heard some snickering in the room, so I just want to make sure that everybody knows exactly what we're dealing with in the act here. It says:

"Choice of therapist or counsellor

"(7) A person who is eligible for funding is entitled to choose any therapist or counsellor, subject to the following restrictions:

"1. The therapist or counsellor must not be a person to whom the eligible person has any family relationship.

"2. The therapist or counsellor must not be a person who, to the college's knowledge, has at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature" or a criminal offence "of a similar nature."

Paragraph 3 goes on to explain, as you've explained it in your brief, that if it's an unregulated therapist, there'll be an exchange of paperwork.

There's no relief from this requirement, as I read this bill, so I think you do have a valid point. How are you to judge an unregulated professional? You're to release this abused person from essentially your process out into the hands of an unregulated person and you have the liability, to some extent anyway, I think to a large extent, as to whether or not you're releasing the survivor into some competent hands or not.

Do you want to elaborate further? We're on time allocation here, and we have an hour and a half tomorrow to deal with this bill, which is probably the most serious health bill we will see over the next decade. Have you



come up with any suggested wording? I would not blame you if you wanted wording to relieve you of that liability, but I suspect that your intentions are better than that, and that is to make sure that the survivors actually get decent counselling and therapy.

**Dr Homer:** You're absolutely right. I think we do have some liability which we're not anxious to undertake. We've worked very hard with ministry officials to try to make the funding proposal workable. This is one area where we still see problems that exist. That's not to say that we're opposed to legitimate therapy and counselling.

One of the alternatives, as we alluded to briefly in our oral brief, is that we support various alternatives that have been put before this committee by the coalition of colleges, one of which is to support existing counselling and therapy services by a number of alternatives, where victims could access services much earlier in the process, where we would have some assurance of the qualifications, training and skills of the therapist providing the service.

We would look forward to moving with that, but it is still, as presently designed, unworkable. I think it's one of the reasons we're saying the idea's right; it's just the process, as it's presently structured, that we don't think is workable. Temporarily withdraw it from the bill so that we can continue to find other, more practical alternatives that are workable.

**Mr Jim Wilson:** A second question: When we dealt with Marilou McPhedran and the CPSO task force and the recommendations coming out of that, my party—I did, actually—during the Regulated Health Professions Act hearings talked about a victims' compensation fund. We were thinking at that time that if the college imposes fines on physicians who are found guilty of sexual abuse, that money would go into a pool of money to help survivors. Under this act, the money goes to Floyd Laughren and you don't get anything, and you have to invoke another section of the act to actually levy your costs back.

I think that's a terrible letdown for survivors of sexual abuse and I don't think they all realize that the government could get rich off this. Then you have to do a second levy on the physician in order to keep enough money in the college process so that you can continue prosecuting abusers. It's crazy, in my opinion. That might be because I'm tired, but I think it's a pretty crazy system.

I want you to comment on that. In particular the question is, I can see a disincentive to fining. Why would you want to fine abuser Dr X \$35,000? That's \$35,000 less that Dr X has to pay when you go to levy him, then, to recover your costs for the investigations and the entire disciplinary process. If I were the college, I wouldn't want a fine. I don't get that money; it goes to the treasury of Ontario. I would simply be invoking the levy section and trying to get back costs so that you have enough money to deal with other abusers down the road. Could you please comment on that?

**Dr Homer:** I would find myself personally in agreement with the point you have just recently made. I would perhaps also direct you, Mr Wilson, and other members

of the committee to pages 19 and 20 in our report. I think you'll find there is a catalogue there of at least nine points, that we don't think the fund in its present format is indeed workable or administrable in a fair and equitable sense.

I can assure you that for the purpose of including things in the report, it's not a complete list by any means. This is a problem area; it always has been with this legislation. It's hung around the neck of this legislation like an albatross. I say that while I will still compliment the ministry. They have tried hard to make the program work. Unfortunately, at this date, it still is not workable, for the many reasons that we've pointed out to you, and it is difficult for us to enthusiastically support something that we don't think is workable and indeed is within the regulatory mandate of our college in the first place.

**Ms Haeck:** A quick question: One of the concerns you raise is about the survivors making a choice of a therapist who may come from the realms of the unregulated. In listening to a range of survivors, as we have over the last two weeks, they definitely have expressed a concern, not to suggest that there can't be problems with someone within the unregulated health care professions, but to a large degree the list of those who have been the most severe in the way of abusing are from the regulated side. We're talking about psychiatrists, doctors, dentists, chiropractors, massage therapists, the five that come to mind.

The survivors have indicated the desire to be able to initiate their own healing by using the mechanisms or therapies out there, not just, say, going to a psychotherapist. As you've heard probably this evening, some of them really feel that support groups have provided them with the mechanism of dealing with their healing in a way that going to another regulated professional has not. Do you not feel that, in essence, since the survivor has made that choice, you are absolved of liability?

**Dr Homer:** I can tell you that I don't think we'll be able to assist the survivor very much in pointing out what the qualifications are because it's in an unregulated area. As to the fact that we are still going to be required to participate in the payment of the fund, and there are amendments in the act that will make that a professional liability, I don't see how that excuses us from it.

What it really asks us to do, in my opinion, is contrary to the purpose of RHPA in the first place. Surely one of the basic tenets of RHPA was to insist on uniformity, consistency of standards, of training, of quality assurance delivery mechanisms within the regulated health profession field. But you are asking us to allow, to condone and to help pay for sending survivors from our process into a system where none of those parameters—

**Ms Haeck:** If I may question that somewhat in the sense that I sat on those hearings myself, yes, I agree that there was a range of accreditation and standardization that were addressed. There was also a range of concerns about the consumer having a right to choose among a range of professionals, so if I decided to go to a chiropractor, it wasn't necessarily getting a referral slip from a doctor in order to do so.

**Dr Homer:** No, but I would point out that a chiropractor is a member of a regulated college.

**Ms Haeck:** It will be, as of January.

**Dr Homer:** Presumably the standards that will ensure to the public that it's safe to do that will be there.

2140

**Ms Haeck:** But there is a range of counsellors out there. We can all discuss our concerns about that, but social work at this point is not a regulated health profession, much as they dearly would love to be. They provide one of the largest mechanisms across this province dealing with counselling and are probably considered in a very positive light, in comparison to some other regulated professions, by the survivor group in particular.

**Dr Edney:** It's important for it to be clear that we do not have this concern because we think that unregulated professionals are unable to do a good job, because I don't believe that's true. We're certainly not saying that the only people who can help survivors are regulated professionals. I'm a family doctor and I refer to non-regulated professionals all the time. We just have a concern, particularly when we have seen, as Dr Homer mentioned, some of our professionals lose their licence and go out and set up as therapists and we have no way to tell the survivors that this is happening. We feel that could be very problematic, but we do not believe that non-regulated professionals are incapable of doing a good job.

**Ms Haeck:** That's a very interesting point which I think we as a caucus should have a discussion about; you're flagging a very interesting point. But I'll leave it there. I know that there's a question from one of my colleagues across the way.

**Mrs Sullivan:** I have three areas that I want to explore. One is with respect to maintaining the register with the information relating to the results of proceedings. We will be putting forward an amendment that would eliminate the time lines for the maintenance of the register, and not only for the sexual abuse areas but for all areas of the profession. I just thought I'd let you know that. I just wanted to comment on it.

The second issue relates to victim impact statements and when they're most appropriate. I wondered if you would comment on that aspect of your recommendations, and after that I want to explore the fund more thoroughly.

**Dr Homer:** I think in principle we would support your first comment about removing any arbitrary time frames from information on the public register.

Victim impact statements: My committee's and indeed my own final conclusion on it is that this is a very valuable thing to happen and to have on the record of a disciplinary hearing. It's important, but I think from a legal sense it goes strictly to the question of penalty assignment. I don't think it has a place in the hearing where the facts are being heard on the merits of the case before a conviction or declaration of innocence is pronounced. But once that is done, I think it's most appropriate to introduce it before the penalty assignment.

**Mrs Sullivan:** In your view, is the wording as it's currently included in Bill 100 appropriate to make that distinction?

**Dr Homer:** I don't think it is, but you asked me what my opinion was. I'll bow to my colleagues who may have a little bit more knowledge of what the amendment or the consolidated report says. But if there is any question about the most appropriate place to put it, I say again it is after a conviction, before a penalty assignment, and I would urge you, as you go through this clause by clause, to consider that point of view.

**Mrs Sullivan:** The next issue relates to the fund. I think there's general concurrence among all parties, with respect to the value of a fund, to ensure that those people who require and want therapy have one method of ensuring access to treatment that they might otherwise not have. I'm quite taken, however, with the arguments that have been placed by the colleges with respect to the conflict-of-interest situation which may arise between the college as the disciplinary body and then the college as the funder of therapies.

You've suggested that there should be alternative mechanisms. I'm wondering if you have any to put forward. You understand that our time lines are very short. We have very limited time tomorrow with respect to shaping amendments and only a couple of hours in third reading, at which point no further amendments can be placed, so tomorrow is the last day. Some of the colleges have indicated that they may well go out of business, that they may go bankrupt with one hearing or two hearings as a result of the kinds of funding mechanisms that are foreseen in the legislation.

When you suggest alternative mechanisms, do you see a scope, by example for an intracollege fund or inter-college fund, I guess, in which case, do you see that should be a fund that is overseen by trustees, and what would the nature of that trusteeship be? Do you see an insurance fund? What are some of the alternative mechanisms that you think should be explored?

**Dr Homer:** I'll take a first crack at it, Mrs Sullivan. It's a complex area. All of those various schemes that you suggested have, at one time or other, certainly been looked at, trying to find out if there are any more workable.

The question with the insurance fund basically was, is it an insurable risk that a third-party agency would be willing to undertake? Should there be dedicated funds, an intercollege fund administered at arm's length by some administrative body? I think that's an alternative that we'd be willing to continue to work towards.

Funds obtained from guilty practitioners through fines: I'm not happy with the fact that they personally now go into the general consolidated revenue fund. I would much rather see them dedicated to victim therapy.

Where moneys can be provided: to expand and enhance existing sexual abuse, counselling services from whatever source, whether that's from participation of professional associations or colleges or indeed the ministry, which I think has an obligation to provide health care services in this province. I would be willing to continue to participate in any of those discussions because it is so unclear as to the best way still to work it even at this late date in the bill.



It pains me to say that I urge the government to withdraw the part of the clause of the legislation that pertains to funding, because it's not workable, it's not fair, it's not equitable and I think it will do harm to survivors more than they realize currently. They are still desperately in need of help in funding and they should get it.

**Mrs Sullivan:** I don't know where we go on that, given that we only have tomorrow afternoon, but the minister is in the room and heard what you had to say. Maybe we'll work something out before tomorrow morning.

**Dr Edney:** One of the things that I think was important was that you heard Ms Halliwell say that you need help earlier. Actually, I think it was the person who spoke before her. That's not going to happen now and that is one of the major issues here, that this funding is too late. We need funding sooner and whatever mechanism we can get that is a better way to do it.

**Ms McSkimmings:** The other thing is that this only provides funding for somebody who has been abused by a health care professional. It doesn't provide any help for somebody who has been used by clergy or other position

of trust; a lawyer, for example. That doesn't seem fair to me. I would rather see the money go into province-wide sexual assault services that could be accessed by anybody who needs that. I worked in a rape crisis centre for 13 years and I know that waiting lists are very long because funding is very short. In my city, the waiting list is a year and a half to two years long for long-term counselling and that simply isn't acceptable.

**The Chair:** Thank you very much for coming before the committee this evening. We appreciate it very much.

Before the committee adjourns, if I could just remind members, under the motion that was passed in the House we must complete clause-by-clause consideration of the bill tomorrow. All proposed amendments must be filed with the clerk of the committee prior to 12 noon. I just wanted to stress that. At 5 o'clock tomorrow those amendments which haven't yet been moved will be deemed to have been moved and we will then have to move to vote on them. I just wanted to indicate again what was in the motion.

The committee now stands adjourned until 3:30 tomorrow.

The committee adjourned at 2149.





*Continued from overleaf*

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York North/-Nord L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

Rizzo, Tony (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Akande, Zanana L. (St Andrew-St Patrick ND) for Mr Rizzo

Mathysen, Irene (Middlesex ND) for Mr O'Connor

Haeck, Christel (St Catharines-Brock ND) for Mr Martin and Mr Owens

Haslam, Karen (Perth ND) for Ms Carter

Sullivan, Barbara (Halton Centre L) for Mr McGuinty

Wessenger, Paul (Simcoe Centre ND) for Mr Hope

White, Drummond (Durham Centre ND) for Mr Rizzo

### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to the Minister of Health

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Gardner, Dr Bob, assistant director, Legislative Research Service

Swift, Susan, research officer, Legislative Research Service

# CONTENTS

Monday 6 December 1993

## **Regulated Health Professions Amendment Act, 1993, Bill 100, Mrs Grier / Loi de 1993 modifiant**

<b>la Loi sur les professions de la santé réglementées, projet de loi 100, M<sup>me</sup> Grier</b> .....	S-653
Task Force on Sexual Abuse of Patients .....	S-653
Marilou McPhedran, chairperson	
Pat Marshall, co-chair, Canadian Panel on Violence Against Women	
Ellen Boyle .....	S-658
Cheryl Brown .....	S-660
Ontario Dental Association .....	S-662
Dr George Sweetnam, president	
John Gillies, executive director	
Linda Samek, director of professional affairs	
Ontario Medical Association .....	S-664
Dr John Gray, chair, committee on sexual abuse issues	
Dr Wendy Graham, member, committee on sexual abuse and chair, committee on women's issues.	
Simcoe Legal Services Clinic .....	S-667
Ian Cameron, staff lawyer	
Transitional Council for the College of Respiratory Therapists of Ontario .....	S-669
Margaret Carter, vice-chair	
Linda Bohnen, legal adviser	
Ontario College of Family Physicians .....	S-670
Dr Marlene Spruyt, president-elect	
Cheryl Katz, executive director	
Robyn Johnson .....	S-673
Jean Halliwell .....	S-677
Ontario Society of Occupational Therapists .....	S-679
Debbie Cameron, vice-president, government affairs division	
Christie Brenchley, executive director	
Mary Kita, co-chair, task force on Bill 100	
College of Physicians and Surgeons of Ontario .....	S-682
Dr Joe Homer, chair, ad hoc committee on Bill 100	
Dr Rachel Edney, chair, patient relations committee	
Judie McSkimmings, public member, discipline committee	
Dr Michael Dixon, registrar	

*Continued overleaf*



S-27

S-27

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 8 December 1993

# Journal des débats (Hansard)

Mercredi 8 décembre 1993

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

**Regulated Health Professions  
Amendment Act, 1993**

**Loi de 1993 modifiant la Loi  
sur les professions de la santé**

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 8 December 1993

The committee met at 1549 in room 151.

## REGULATED HEALTH PROFESSIONS

## AMENDMENT ACT, 1993

## LOI DE 1993

MODIFIANT LA LOI SUR LES PROFESSIONS  
DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 100, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 100, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

**The Chair (Mr Charles Beer):** The standing committee on social development is called to order. We are considering Bill 100, An Act to amend the Regulated Health Professions Act, 1991. We meet this afternoon for clause-by-clause consideration of the bill. Just before starting that, I would remind all members that we are charged by resolution of the House that at 5 o'clock we must begin to put all of the votes regardless of where we are with the amendments. It's approximately a quarter to 4, 10 to 4, so we have about an hour and 10 minutes.

Turning then to the bill, shall section 1 of the bill carry?

**Mrs Barbara Sullivan (Halton Centre):** I'd request a ruling of the Chair with respect to section 22, subsections 95(1), (2.1) and (2.2) of schedule 2 to the act, which is an amendment placed by the government. I'm just providing notice of that. We want to flag it now because we believe that there probably won't be time for debate on the issue.

**Mr Jim Wilson (Simcoe West):** Mr Chairman, may I speak on that point?

**The Chair:** Can you just repeat again which section it was?

**Mr Jim Wilson:** It was the very last amendment, regulatory authority.

**The Chair:** I'm prepared to hear discussion on that.

**Mr Jim Wilson:** I very strongly believe that this simply came out of the blue. It's not a regulatory authority. Particularly, section 95 of schedule 2 is amended by adding the following subsections. Subsection (2.1) deals with the quality assurance committee of the colleges. It is certainly my very strong opinion that we did not have a discussion with witnesses—in particular, the Ontario Medical Association and other professional associations—with respect to the quality assurance committee and the new powers that it will be granted under this government amendment. On that basis, I would ask that you rule it out of order. It was not part of our discussions at all before this committee and it's simply been slipped in through the back door as the last amendment, hoping that members wouldn't notice it.

I would point out that these new sweeping powers for the quality assurance committee go far beyond any discussions that we had. We did not have discussions about quality assurance. The consolidated act that was

provided to members of this committee simply referred that the government would allow that under the definition of sexual abuse, clause 3(c), remarks and behaviour, in certain circumstances that could bypass the disciplinary process and go to remediation. They had not, up to this point, spelled out what they meant by remediation. I don't think you should allow this particular amendment to be introduced, because it contains new provisions, sweeping powers that go beyond the scope of Bill 100.

The purpose of the act, and the government is introducing a purpose clause, is to deal with sexual abuse. This expands the power of the quality assurance committee, not only to deal with sexual abuse, which I believe is the intent of the act and the intent of the government, but to deal with all matters referred to that committee. It's far too sweeping and I think beyond the scope of what the mandate of this committee is. I'd like a ruling on that.

**Mrs Sullivan:** Mr Chairman, I think you will know that we have indicated in the past that we have appreciated much of the openness the government has displayed with respect to the development of amendments to this bill, and the government has shared with us the amendments that it was considering along the way as issues were developing.

As of Monday, we had a proposed amendment with respect to section 22 of the bill, section 95 of schedule 2 to the act, which amended subsection 95(1) by adding various paragraphs with respect to matters that the government could make regulations around with respect to professional misconduct etc.

Had we gone into committee yesterday afternoon without the bomb threat occurring, we would have discovered that in the amendments, which were filed at noon on the required day, an entire new matter had been added—there had been no discussion in public hearings—that would further amend section 95 of schedule 2 by adding additional subsections, as subsection (2.1), an entire new subsection of that bill.

We've had no discussion of this. We understand that these issues were in fact dealt with at some length in the public hearings in the entire process of the development of the Regulated Health Professions Act in the beginning. We are very concerned, however, that not only members of the committee did not see this adjusted amendment prior to the final tabling of amendments with very significant movement away from what we had been looking at and were prepared to debate, but also the players that are most involved, the colleges themselves, the councils and the associations representing health care professionals also had not seen these recommendations. I will tell you that what concerns me is that because they were slipped in, if this is ruled out of order, what may well be a useful part of the bill will also probably be ruled out of order because it too is an addition to the original bill.

But this goes well beyond the bounds, frankly, of an appropriate parliamentary approach to the introducing of amendments to bills, not only in this bill. In Bill 50 we have seen entire intents changed as a result of the amending process. This is one clear instance of that and we just don't think it's right. We do not think it's parliamentary, we do not think it's fair to those who are involved in the legislative process, and we don't think it's fair and just to those people who did not know that this was an issue to be before us and who did not have an opportunity to comment on it.

**Mr Larry O'Connor (Durham-York):** I think that it's important that as we go through this debate on this issue we have heard from a lot of people who have come to this committee. We heard from victims who have never felt safe as a result of incidents that have taken place by medical practitioners, and hence the result in this bill.

In trying to develop a bill and some regulations that are going to address this very serious situation that shouldn't be allowed or tolerated, and won't be, we've had to take a look at exactly how we can provide the mechanisms.

The College of Physicians and Surgeons came to this committee just this Monday, made a submission to us. Those of you who have the submission in front of you, on page 6 of it you'll notice where they put down assessment and remediation:

"The ministry's concept of assessment and remediation appears to be designed to provide this flexibility. Without detailed wording, it is difficult to judge, but as described, it should allow colleges to determine the nature of the problems. However, if remediation is to work effectively, colleges must have the ability to require that it be completed successfully by practitioners. Otherwise the survivors will see this as a way to somehow protect the practitioners from the process."

The whole intention behind this isn't to protect practitioners. The college's role isn't there just to protect practitioners; the college is there so that the public can go to it if they have a very serious problem and complain. We've heard from people who have come to these committee hearings as victims who have never felt comfortable and satisfied that the college was there acting in their best interest.

Far be it from any of us to say what is best for these victims. We're trying to offer them an opportunity here that is going to allow a process to take place so that they can feel some comfort in this. I don't think this amendment before us should be ruled out of order.

I think all of the medical practitioners and all the regulated health professions out there should take a look at this, take a look at exactly what is being provided. Certainly there was far much more being provided than should have been provided in the past. Take a look. What we're trying to offer here is an avenue by which the colleges can take a look at this, and they have to have that ability. The reason we're here today is because the colleges haven't always taken a look at the best interests and the needs of the victims. That's what we're here for. As legislators we've got a role to play to make sure that

the best possible legislation is there that is going to protect the victims while allowing the best opportunity for the practitioners who are accused avenues as well.

**1600**

**The Chair:** Thank you. The parliamentary assistant.

**Mr Paul Wessinger (Simcoe Centre):** I'm not going to deal with the merits of this provision at this time because I think it's really a technical matter. I'm going to ask legal counsel to respond, but before doing so I might make just a couple of preliminary comments.

First of all, I think we have to look at the context. We're dealing with An Act to amend the Regulated Health Professions Act. The particular provision, section 22, is a provision to make regulations, so I would suggest that when looking at the matter of whether it's out of order, you have to look at the original Regulated Health Professions Act as well as the amendment to determine whether the subject matter is within the framework of the act as amended. I would suggest that the criteria should be looked at.

With that, I'll just turn it over to legal counsel.

**Ms Christine Henderson:** Christine Henderson, legal services branch, Ministry of Health.

As you know, Bill 100, at first reading, required mandatory cross-profession reporting of incompetence, incapacity and designated acts of professional misconduct, as well as sexual abuse. As you also know, the government proposed that the mandatory reporting of incapacity and incompetence and designated acts of professional misconduct be removed from the bill.

However, a number of presenters spoke to the issue of mandatory reporting of incompetence, requesting that something be done about that issue. As Mr O'Connor just stated, the College of Physicians and Surgeons spoke to this issue and presented a letter to the committee on this issue around the substandard practice of practitioners. At present, unless—

**Mrs Sullivan:** On a point of order, Mr Chairman: I believe the issues that are being discussed at this current time should relate to the legislative and parliamentary questions as to whether the amendment is in order and not speak to the particular content of the amendment. In fact, the reference that Mr O'Connor makes to the CPSO's recommendation—

**Mr Stephen Owens (Scarborough Centre):** That's not a point of order.

**Mrs Sullivan:** —related to an issue where the CPSO had not even seen the proposal included in this amendment.

**The Chair:** An important issue has been raised here and I am providing some leeway to make sure that we understand the issues that are being put before me, because I'm going to have to rule on this. So please continue.

**Ms Christine Henderson:** Okay, and I would ask our legislative counsel to speak to the technical matter that I think Mrs Sullivan's raising after I finish, so I'll be brief.

At present, unless practitioners, as you know, fall strictly within the provisions around professional miscon-



duct—fitness to practise, for example—the substandard practitioner cannot be dealt with until actual harm is caused to a patient.

As offered, as Mr Wessinger stated, this amendment is enabling legislation. It permits colleges, as a voluntary matter, to make regulations around these programs. At present, I would also draw your attention to subsection 95(2) of the code, which states that regulations made under paragraph 25 of subsection (1), which provides for regulations to be made prescribing quality assurance programs, may require members to participate in continuing education programs. An element of non-voluntariness therefore is currently within the code, within the power of the college councils to make regulations in this regard.

These programs, if a college determined to make such regulations around quality assurance programs, would provide for limited restrictions. As was pointed out, the vast majority of practitioners voluntarily work with colleges to bring up their skills, whether it be communication skills, skills around their knowledge or judgement in particular matters. But what these limited regulations would provide for would be limited restrictions upon the practice of practitioners who refused, after they were evaluated under the programs which are permitted under the statutory provisions, to participate in such programs or who unsuccessfully participated in these programs.

The programs contemplated under the scheme, as you will note, and the powers provided to the colleges and to the quality assurance committees are very similar to the programs that are contemplated by way of regulation in relation to assessment and remediation in relation to clause 1(3)(c), sexual abuse. The quality assurance committee would have a broad mandate, therefore, to deal with these kinds of problems, whether they be of a sexual abuse nature, words and gestures of a sexual nature, or of substandard practice not meeting actual harm of a patient yet.

**The Chair:** Do you want to hear first from legislative counsel? I know both opposition critics want to add something. Do you want to do that now or after legislative counsel has spoken?

**Mrs Sullivan:** We seem to be speaking to the content of the proposal—

**The Chair:** I'm sorry, but just before we go on, do you want me to ask legislative counsel to speak now?

**Mr Jim Wilson:** Yes, okay.

**Mrs Cornelia Schuh:** I am Cornelia Schuh, deputy chief legislative counsel.

It seems to me that the question the Chair will need to determine here is, is the motion within the scope of the bill as it was printed at first reading?

I think the only concern relates to clauses (a), (b) and (c) of proposed subsection (2.1) of section 95. That's the material that's being added by what would be subsection 22(2) of the bill if this motion were moved and passed, dealing with the quality assurance committee. Clauses (d), (e) and (f) deal with matters that are referred to the quality assurance committee after an investigation into a possible act of sexual abuse.

Are these clauses (a), (b) and (c) within the scope of

the bill? I don't think it's an absolutely open-and-shut case. I can't say obviously they are within the scope of the bill or obviously they are not.

The argument that you would make if you wanted to demonstrate that they are not within the scope of the bill is to say there's nothing about the quality assurance committee and its activities in the first reading bill.

I personally think the better view is that it is within the scope of the bill because the first reading bill dealt not only with matters relating to sexual abuse, but more generally with procedural issues, issues of substandard practice: reporting on incompetence and incapacity, for example. If you look at the last part of the explanatory notes, there are references to a variety of procedural and other changes. Most of those don't relate specifically to the issue of sexual abuse by health professionals.

So, to sum up, I would say it's not an absolutely clear, open-and-shut case. I would tend to recommend that those clauses do fall within the scope of the bill, but that depends on how the Chair views the scope of the bill. There is nothing in the printed bill about the quality assurance committee as such.

1610

**Mr Jim Wilson:** Following on what legislative counsel has said, if we're to—I mean, we're time-limited. It comes as somewhat of a shock to me that the government would be seeking such wide-ranging regulatory authority under this section. In the discussions I had with groups and in the testimony that we heard before the committee—and I will deal with the CPSO testimony—I certainly did not have a clear picture at all that this is what the government envisioned. In the information provided to the committee, and I want you to use this in your ruling, if you can, Mr Chairman, in the consolidated act, we were given a very vague sentence with respect to the government's intention.

This is a serious matter. I recall the discussions almost verbatim about the quality assurance committee during the Regulated Health Professions Act hearings. The quality assurance committee was not subject to testimony from witnesses during the hearings on this bill, and I don't know how you can rule that it is within the scope of this particular act.

If my voice is quivering, it's because I'm quite, quite angry about this. The government knows that we're under time constraints, that by 5 o'clock, whether or not we've had an opportunity to deal with all of the amendments before us today, they would be deemed to have been entered and dealt with by the committee. I think that for the sake of fairness, and given the rather unequivocal statement from legislative counsel, you should err, if there is to err, on the side of the fact that this was not discussed during the hearing process and therefore should not be considered part of the scope of this bill.

**Mrs Sullivan:** I think that in this bill, as in other bills this government has presented, we have seen the intent of legislation substantially altered from an in-principle vote at second reading to what the final amendments that are placed on the table relate to.

By example, with Bill 50 we have a totally different

piece of legislation than was introduced to the House. For our part, with that particular bill, we were terrified of not demanding that the out-of-order amendments be ruled out of order because we were afraid that the government would automatically go back to the first bill and it would become the law of the province. That would be bad law.

In this case, we have a situation where there has been an all-party attempt, I believe, to assure that the process was going to move ahead and that the fairest approaches were being brought forward. That means that those fair approaches—and we recognize that the government has been fair in providing us with copies of its proposed amendments. However, this proposed amendment creates some difficulty because we did not have a broad-based discussion in public testimony before the committee. I believe that distorts the parliamentary process. That is my argument.

These amendments may well stand on their merit had we heard the discussion about them, but they may well have fallen as well. Unfortunately, my suspicion is that without that discussion, they will proceed.

**The Chair:** Any other comment on this issue?

**Mr O'Connor:** Just briefly, Mr Chair, as you make your decision and ruling on this, I just take a look back at when we first started the hearings in this room a couple of weeks ago and started talking about this very serious bill and were presented with the consolidated report. On the final page of it, they talked about the RHPA provisions and said that they would be prescribing, in regulations, a quality assurance program. I think what they've done here, as requested by many of the people who had made presentations—they are here right before us, as was put before us in the consolidated report. So I just would like to remind folks that we have seen this provision through the consolidated report.

**The Chair:** Parliamentary assistant?

**Mr Wessenger:** I'll just reiterate that the position of the legislative counsel has indicated that the better view of these provisions is that they do fall within the scope of the act. I'd just like to remind the Chair of that.

**The Chair:** This is an important issue that has been raised. I want to just call a brief recess so that I can consult with the legislative counsel and the clerk. The committee stands adjourned.

*The committee recessed from 1616 to 1630.*

**The Chair:** I would now call the committee back to order. I am prepared to make my ruling. After having listened to the discussion of members regarding whether this section, this amendment is in order and after having discussed it with legislative counsel and the clerk, it is my ruling that the proposed amendment is in order. We will then proceed with the bill.

Shall section 1 of the bill carry? All those in favour? Opposed? Carried.

Shall section 2 of the bill carry? All those in favour? Opposed? Carried.

Now, new section 2.1. I have two amendments. The first one is a government amendment.

**Mr Wessenger:** I move that the bill be amended by

adding the following section:

"2.1 The act is amended by adding the following section:

"Same

"43.1 Subject to the approval of the Lieutenant Governor in Council, the minister may make regulations governing funding under programs required under section 85.7 of the code, including regulations,

"(a) prescribing the maximum amount or a means of establishing the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse;

"(b) prescribing the period of time during which funding may be provided for a person in respect of a case of sexual abuse."

The purpose of this amendment is to allow the minister to establish the maximum amount payable for counselling and therapy, which I think has been discussed, of up to \$10,000, and the period of time that's proposed will be up to a period of five years.

**Mr Jim Wilson:** I have a question. Given that the order from the House doesn't allow us to change anything in our amendments, what about the numbering of amendments? Because my next amendment is 2.1. We have the most bizarre order from the House that says you can't touch anything on these pages. So how in the world are we to deal with amendments if the numbering's all screwed up? I can tell you it is, because different legislative counsel did different things. They didn't do anything wrong at their end; that's the way it's supposed to be done at their end. Can we have a ruling on that, Mr Chair?

**The Chair:** I'll ask legislative counsel to speak to that.

**Ms Schuh:** I think that the numbering can be handled editorially by our legislative editors when the bill is reprinted, when things will be sorted out and appear in the proper order.

**Mr Jim Wilson:** That's normally the process, but we're not normally under an order from the House such as the one we're under now.

**Ms Schuh:** I wouldn't have read the time allocation motion as preventing editorial corrections to the bill, but we are in a novel situation.

**The Chair:** The Chair rules in favour of editorially correct changes.

Any discussion, then, of this government amendment? If not, shall the government amendment 2.1 carry? In favour? Opposed? Carried.

**Mr Jim Wilson:** When I read this in, should I be reading it as 2.1 or 2.2?

**The Chair:** I would do it as 2.2.

**Mr Jim Wilson:** I move that the bill be amended by adding the following section:

"2.2 The act is amended by adding the following section:

"Review of sexual abuse provisions

"43.1 The standing committee on social development



shall, within three years after proclamation of this act, undertake a comprehensive review of the provisions of this act relating to sexual abuse and shall, within one year after beginning that review, make recommendations to the Legislative Assembly regarding amendments to those provisions."

This is simply a recognition of the importance of this act and we're recommending that the standing committee on social development undertake a comprehensive review of the act within three years of proclamation.

**Mr Wessenger:** We'll not be supporting this amendment. There is already provision in the bill for a review by the advisory committee after five years.

**The Chair:** Further comment? Shall the Conservative amendment carry? All those in favour? Opposed? It is lost.

We then move to section 3 of the bill, and the first amendment is Mr Wilson's.

**Mr Jim Wilson:** I will not be introducing that amendment.

**The Chair:** You are withdrawing it. Government amendment.

**Mr Wessenger:** I wonder if it would be satisfactory to allow the Liberal motion to be moved first.

**The Chair:** Okay. Mrs Sullivan if you would.

**Mrs Sullivan:** I move that subsection 1(4) of schedule 2 of the act, as set out in section 3 of the bill, be struck out and the following substituted:

"Exception

"(4) For the purposes of subsection (3), 'sexual nature' does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided."

**Mr Wessenger:** We will be supporting this amendment.

**Mr Jim Wilson:** I just wonder what type of favouritism's going on here when the PC motion is also identical to the Liberal motion. Did somebody cook a deal?

**Mr Wessenger:** I might say that the numbering was correct on the Liberal motion but not correct on the PC motion.

**Mr Jim Wilson:** That's why I had to ask whether we could change numbering. Mr Wessenger, that's going to be dealt with editorially, so it's a moot point.

**Mr Wessenger:** There wasn't any preference, Mr Wilson.

**Mr Jim Wilson:** Mr Chairman, I'll be supporting the motion, obviously.

**The Chair:** All those in favour of the Liberal motion? Opposed? Carried.

Now we turn to the government motion.

**Mr Wessenger:** That will be withdrawn.

**The Chair:** Mr Wilson, you have a further amendment?

**Mr Jim Wilson:** Sorry, withdrawn.

**The Chair:** Okay, just to be correct then, you have withdrawn the amendment to subsection 1(5)?

**Mr Jim Wilson:** Yes.

**The Chair:** Please go ahead then with your—

**Mr Jim Wilson:** I withdrew the one that was identical to the Liberal motion that just passed.

**The Chair:** Right. Please go ahead then.

**Mr Jim Wilson:** I move that section 3 of the bill be amended by adding the following subsection:

"(2) Section 1 of schedule 2 to the act is amended by adding the following subsection:

"Purpose, sexual abuse

"(4) The purposes of the provisions of this code relating to sexual abuse of a patient by a member are,

"(a) to respond to the concerns of the community with regard to incidents of sexual abuse of patients by members;

"(b) to recognize the need to protect all patients from sexual abuse and in particular to protect women, who are the people primarily subject to sexual abuse;

"(c) to encourage the reporting of incidents of sexual abuse of patients by members; and

"(d) to take the necessary action to prevent sexual abuse in the context of the inherently fiduciary relationship between members and their patients."

This motion is in response to requests by survivors. They asked that we put in some sort of preamble in the bill. This is an attempt to explain the purpose of the bill.

In my view, the preamble at the beginning of the RHPA, in Bill 43, would not be appropriate. It's more appropriate in this section of the act dealing specifically with sexual abuse. The amendment sets out the general purposes, the measures in the bill designed to combat patient sexual abuse. I note that it is similar to the government amendment on this topic.

**Mr Wessenger:** We will not be supporting this amendment because we prefer our own amendment respective to purpose.

**The Chair:** Further commentary? I'll put Mr Wilson's amendment.

**Mr Jim Wilson:** Can I have a recorded vote?

**The Chair:** A recorded vote. Shall Mr Wilson's amendment carry? All those in favour?

**Ayes**

Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Haack, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sullivan, Sutherland, Wessenger.

**The Chair:** The motion is defeated.

Shall section 3 of the bill, as amended, carry? All in favour? Carried.

Section 3.1, government amendment.

**1640**

**Mr Wessenger:** I move that the bill be amended by adding the following section:

"3.1 Section 2 is amended by adding the following section:

"Statement of purpose, sexual abuse provisions



"1.1 The purpose of the provisions of this code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members."

**Mr Jim Wilson:** I just felt that the government's amendment doesn't go as far as the PC amendment. I question why they wouldn't support a more comprehensive amendment.

*Interjection.*

**The Chair:** The question is, did the parliamentary assistant say "schedule 2"?

**Mrs Sullivan:** No, he said "section" but he meant "schedule."

**The Chair:** Do you want to say "schedule"?

**Mr Wessinger:** Yes, "Schedule 2 is amended by adding the following section."

**The Chair:** So noted.

Shall the government amendment carry? In favour? Opposed? Carried.

Shall section 3.1 of the bill carry, as amended? Carried.

Shall section 4 of the bill carry? In favour? Opposed? Carried.

We then move to section 5, a Liberal amendment.

**Mrs Sullivan:** I move that subsections 5(2) and (3) of the bill be struck out and the following substituted:

"(2) Paragraph 3 of subsection 23(3) of schedule 2 is repealed and the following substituted:

"3. The results of every disciplinary and incapacity proceeding,

"(i) in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it,

"(ii) in which a member was found to have committed sexual abuse as defined in clause 1(3)(a) or (b), or

"(iii) in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the discipline or fitness to practise committee."

Basically this amendment is put forward to ensure that the register of misconduct is open in perpetuity rather than in the three years of the existing act or the six years that were recommended in this bill. I think the government had an amendment that would have maybe moved it to 10 years or something. But we feel that when there has been a revocation of registration, that is an important matter for the public to know. When there has been a reprimand, it is an important matter for the public to know. The relevance of those issues doesn't end in a limited period of time.

**Mr Wessinger:** The government does have its own amendment which we believe is more complete because it does deal with appeals and also defines the results of a proceeding. For that reason, we won't support the Liberal motion.

**Mr Jim Wilson:** I won't be supporting this amendment. There's a PC amendment that simply calls for no time limitation on the record to be kept by the college.

**The Chair:** Shall the Liberal amendment carry? All those in favour? Opposed? It is lost.

We come next, then, to the government amendment.

**Mr Wessinger:** I move that section 5 of the bill be struck out and the following substituted:

"5(1) Subsection 23(2) of schedule 2 is amended by adding the following clause:

"(e.1) where findings of the discipline committee are appealed, a notation that they are under appeal.

"(2) Section 23 of schedule 2 is amended by adding the following subsection:

"Same

"(2.1) When an appeal of findings of the discipline committee is finally disposed of, the notation added to the register under clause (2)(e.1) shall be removed.

"(3) Paragraph 3 of subsection 23(3) of schedule 2 is amended by striking out 'three years' in the second line and substituting 'six years.'

"(4) Subsection 23(3) of schedule 2 is amended by adding the following paragraphs:

"3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1(3)(a) or (b), the results of the proceeding.

"3.2 Information described in clause (2)(e.1) related to appeals of findings of the discipline committee.

"(5) Section 23 of schedule 2 is further amended by adding the following subsection:

"Meaning of 'results of proceeding'

"(7) For the purpose of this section and section 56, 'result,' when used in reference to a disciplinary or incapacity proceeding, means the panel's finding, particulars of the grounds for the finding, and the penalty imposed, including any reprimand."

**Mrs Sullivan:** The real difficulty that exists here is that the amendment I put forward would have ensured that the register was open to those who wanted to consult it with respect to decisions made not only on sexual abuse but on incapacity and incompetence, in perpetuity, or as long as the register is maintained or, I suppose, until the member dies.

The government's recommendation, unfortunately, only provides the open register for sexual abuse cases. I had hoped there would be a way, through parliamentary drafting, to consider my amendment in those other areas along with the government amendments, because I think the government amendments with respect to appeals are in fact worthwhile.

It won't work. I guess this is better than nothing, but I would have liked to have had the whole loaf.

**Mr Jim Wilson:** I just wanted to ask the parliamentary assistant why the government decided on the six-year limitation. Could you explain why we went from three to six when we've had a request for no restriction?

**Mr Wessenger:** I'll ask either policy or leg counsel to explain that.

**Ms Christine Henderson:** It was felt there should be a longer term for the recording of this information on the public register. However, there is also recognition that whereas sexual abuse of 1(3)(a) and 1(3)(b) sorts should have a lifetime record because of the aspect of the protection of the public, it was brought to our attention that many other jurisdictions, for example, US self-governing bodies, will require any notice on the register to be brought to their attention and will, in some cases, automatically bar that practitioner from receiving a licence in that other jurisdiction.

When we're looking at the many and varied grounds of professional misconduct, which range from 1(3)(a) sexual abuse to grounds of breach of a record, we had to consider, on balance, what might be fair, and I think took a balanced approach.

There may be other comments from our policy analyst.

**Ms Ella Schwartz:** I'm Ella Schwartz, the policy analyst. I think that's fair to say, that we were looking for a balance between the different concerns.

**Mr Jim Wilson:** I accept what counsel has said, and it does seem somewhat reasonable. My follow-up question, though, would be with respect to—I can't find the particular section at the moment—the requirement when a patient, under the counselling and therapy fund, decides to go to an unregulated professional, the member's college is required to try to ascertain whether that unregulated person—I'm just trying to think of the case that was made to us that if a physician is kicked out of the College of Physicians and Surgeons and ends up in private practice and hangs out a shingle as a therapist of some sort. Under this act there's a requirement for the College of Physicians and Surgeons to notify the patient, where they know, that that particular physician had committed a sexual abuse offence in the past. If you don't have a lifetime record, how would the college do that? I have some difficulty there. Perhaps you could just clarify that for me.

1650

The other thing is that this record is contained in media reports. If you don't have a lifetime record, if physician X, who's been kicked out of the college, gets in trouble at some point, the public can't go back to the college, because if it's outside the six-year period—have I got that right or have I got that wrong?

**Mrs Sullivan:** No, sexual abuse is lifetime.

**Mr Jim Wilson:** Clauses 1(3)(a) and (b) are lifetime? Then I'm sorry; I've got that wrong.

**Mr Wessenger:** Mr Chair, before we vote, it's been pointed out that I may have made one error with respect to reading subsection (7). Just in case I did, could I correct that in case it was made? It's "particulars of the grounds for the finding."

**The Chair:** In the third line.

**Mr Wessenger:** In the third line, yes.

**The Chair:** There have been many tests of reading and spelling of late.

**Mr Jim Wilson:** Now that I've been corrected, for incapacity and incompetence, is that the six-year limitation?

**Mr Wessenger:** I'll ask counsel to respond to that.

**Ms Christine Henderson:** Yes.

**Mr Jim Wilson:** So we don't consider that serious? Is that what you're saying? But sexual abuse stays on the record for life.

**Mrs Sullivan:** You should have voted for my amendment.

**Mr Jim Wilson:** Your amendment had other flaws, Mrs Sullivan. I won't get into it. Mine's much simpler.

I just don't understand. It seems to me there's somewhat a double standard there.

**Ms Christine Henderson:** Could I have a moment to consult with the parliamentary assistant?

**The Chair:** Yes, take a moment.

**Mr Wessenger:** We'd like to request a very short recess to consult with leg counsel.

**The Chair:** We can have a short recess. I would just remind everyone that we are at approximately six minutes to 5, and at 5 o'clock—

**Mr Jim Wilson:** We can't have a recess, then. Could you just get back to me and we'll move on to the next amendment? You're going to vote for it anyway.

**Mr Wessenger:** Mr Wilson, I will indicate that if there's an all-party agreement, we could consider such an amendment.

**Mr Jim Wilson:** You can't do that without going back to the House.

**Mrs Sullivan:** You can't do that. Besides that, we're under time allocation.

**Mr Wessenger:** That's right; we can't.

**Mr Jim Wilson:** I just want to point out that I think you're caught in your own web here.

**The Chair:** We're under time allocation. We're under very strict rules of procedure and the Chair is not in a position to accept an amendment.

**Mrs Sullivan:** And you already voted against my amendment anyway.

**The Chair:** I will then put the government amendment. Shall the amendment carry? All those in favour? Opposed? Carried.

**Mr Jim Wilson:** I move that the government motion amending section 5 of the bill be amended by striking out subsection 5(3) of the bill and substituting the following:

"(3) Paragraph 3 of the subsection 23(3) of schedule 2 is amended by striking out 'completed within three years before the time the register was prepared or last updated' in the second, third and fourth lines."

**The Chair:** Discussion?

**Mr Jim Wilson:** I'll waive discussion, Mr Chair.

**Mr Wessenger:** We will not be supporting this amendment.

**The Chair:** All those in favour of Mr Wilson's motion? Opposed? The motion is lost.



Shall section 5 of the bill, as amended, carry? Carried.  
Section 5.1, a government amendment.

**Mr Wessenger:** I move that the bill be amended by adding the following section:

"5.1 Section 26 of schedule 2 is amended by adding the following subsection:

"Same

"(3) If the complaint is about sexual abuse as defined in clause 1(3)(c), the panel may refer the matter to the quality assurance committee."

**The Chair:** All those in favour? Opposed? Carried.

Shall section 6 of the bill carry? Carried.

Shall section 7 of the bill carry? Carried.

Shall section 8 of the bill carry? Carried.

Section 9, a government amendment.

**Mr Wessenger:** I move that section 42.1 of schedule 2 to the act, as set out in section 9 of the bill, be struck out and the following substituted:

"Same

"42.1 Evidence of an expert led by a person other than the college is not admissible unless the person gives the college, at least ten days before the hearing, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence."

**The Chair:** All those in favour? Carried.

Shall section 9 of the bill, as amended, carry? Carried.  
On 9.1, Mr Wilson.

**Mr Jim Wilson:** Given the inflexibility of the order from the House, this amendment, which was meant to be introduced on behalf of survivors, I'll have to withdraw. It needs some fine-tuning, which we're not able to do.

**The Chair:** The amendment is withdrawn. Shall section 10 of the bill carry? Carried.

Section 11, a government motion.

**Mr Wessenger:** I move that subsection 11(2) of the bill be struck out and the following substituted:

"(2) Paragraph 5 of subsection 51(2) of schedule 2 is repealed and the following substituted:

"5. Requiring the member to pay a fine of not more than \$35,000 to the Minister of Finance.

"5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the college for funding provided for that patient under the program required under section 85.7.

"5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the college to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1."

**Mr Jim Wilson:** I won't be supporting this government amendment. You'll note that there's a PC amendment which requires the fine money to not go to the government or the Minister of Finance but that the money go to the survivors' fund. I repeat my disgust that the way the government sold this bill is contrary to what the bill now contains and that the government will in fact get

rich off the backs of sexual abusers.

**Mrs Sullivan:** We also will not be supporting this amendment because the fines will be directed to the Minister of Finance rather than to the colleges' funds, which would otherwise be used for patient rehabilitation and counselling.

We don't see this bill in any way as a revenue bill. We believe that this change in the fine level of \$25,000 to the Ministry of Finance in fact makes this a revenue bill. We don't think it should be one and we feel this is an error.

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Shall the government amendment carry? I am going to ask the clerk to take the names. All those in favour?

**Ayes**

Carter, Haeck, O'Connor, Rizzo, Sutherland, Wessenger.

**The Chair:** All those opposed?

**Nays**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** The amendment is lost. It is now 5 o'clock.

**Mr Wessenger:** The amendment should be carried, not lost.

**The Chair:** I'm sorry. What did I say?

**Mr Wessenger:** You said it was lost.

**The Chair:** I'm sorry. Carried. The Chair is getting confused.

**Mr Wessenger:** We're all doing it today.

**The Chair:** It is now 5 o'clock, and the direction we have from the House is that at 5 o'clock we must put all the remaining questions. I will now proceed to do that. Again, I have to indicate that all we can do is move and vote.

**Mr Jim Wilson:** I don't think we can move; they're deemed to be moved.

**The Chair:** Sorry, they're deemed moved. We can't read them in. We just have to vote.

**Mrs Sullivan:** Can we discuss them?

1700

**The Chair:** No. I'm sorry. Again, perhaps just for those who are watching—

**Mr Jim Wilson:** Hold on. Just so I'm clear, then, we can't move them and we can't talk about them?

**The Chair:** They are deemed to have been moved, and we may simply vote. For those who are watching the proceedings, I would just remind everyone that we are under the direction of the House in terms of our procedures, which stated that at 5 o'clock, all the remaining amendments and articles had to be voted on without debate and without reading the amendments into the record.

With that, the next is the Conservative amendment.

**Mrs Sullivan:** A recorded vote.

**The Chair:** Recorded vote. All those in favour?



**Ayes**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** Opposed?

**Nays**

Carter, Haeck, O'Connor, Rizzo, Sutherland, Wessenger.

**The Chair:** The amendment is lost. The next amendment is a government amendment, subsection 11(3). All those in favour? Opposed? Carried.

Conservative motion to 11(3). All those in favour? Opposed? It is lost.

Shall section 11 of the bill carry as amended? Carried.

Section 12, government amendment, section 53.1. Shall that amendment carry? Carried.

**Mrs Sullivan:** Just a clarification.

**The Chair:** I'm sorry. We have to simply vote and we cannot discuss these under the rules of the House.

Shall section 12, as amended, carry? Carried.

Shall section 13 carry? Carried.

Section 13.1, a government amendment. Shall it carry? Carried.

Shall section 14 of the bill carry? Carried.

Shall section 15 of the bill carry? Carried.

Shall section 16 of the bill carry? Carried.

A government amendment, section 16.1. Shall the government amendment carry? Carried.

Shall section 17 of the bill carry? Carried.

Section 18, a government amendment. Shall the government amendment carry? Carried.

Liberal amendment to section 18. Shall the Liberal amendment carry? All those in favour?

**Mr Jim Wilson:** What happens if it's the same motion?

*Interjection.*

**The Chair:** Shall the Liberal amendment carry? All those in favour? Opposed? The amendment is lost.

Conservative amendment to section 18. Shall the Conservative amendment carry?

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Recorded vote. Shall the Conservative amendment carry? All in favour?

**Ayes**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** Opposed?

**Nays**

Carter, Haeck, O'Connor, Rizzo, Sutherland, Wessenger.

**The Chair:** The Conservative amendment is lost.

Another Liberal amendment to section 18. Shall the Liberal amendment carry? All those in favour? Opposed? The Liberal amendment is lost.

A government amendment to section 18. Shall the government amendment carry? Opposed? Carried.

Another government amendment to section 18. Shall it carry? Opposed? Carried.

A Liberal amendment to section 18. Shall the Liberal motion carry?

**Interjection:** Is that the same amendment?

**Mr Wessenger:** It's the same. It's the same as we've already passed, so I don't care which one you put down.

**The Chair:** Okay. That motion in effect—the government amendment is carried, so I will not put the Liberal amendment. Perhaps we could have a brief pause here just on a technical matter.

We just voted on a government amendment, section 18, subsection 85.2(1), and then it is followed by a Liberal amendment which is to the same—

**Mrs Sullivan:** Exactly the same.

**Mr Wessenger:** Exactly the same.

**The Chair:** It has been indicated that the Liberal amendment is exactly the same. We have already voted in favour of an amendment, so—

**Mr O'Connor:** It doesn't appear to be quite the same. The subsections appear to be—

*Interjections.*

**The Chair:** Just one second then. With respect, the Liberal amendment is similar to the government amendment which was just supported. The wording is the same. All right? Therefore we do not need to vote on the Liberal amendment.

**Mr Wessenger:** Mr Chair, I think the question has to do with section 85.1. We haven't voted on section 85.1, have we?

**The Chair:** We have voted down to—could I have everybody's attention, please, just so you know what we have voted on in section 18.

We have voted on the government amendment, section 18, 85.1(1) and (2). That was carried.

We then voted on the Liberal amendment, subsection 85.1(1), which was lost.

We then voted on the Conservative amendment to section 18, 85.1(3.1), which was lost.

We then voted on the Liberal amendment, section 18, 85.1(4), which was lost.

We then voted on the government amendment, 85.1(4), which was carried.

We then voted on the government amendment, subsection 85.2—

*Interjection.*

**The Chair:** Excuse me. Just let me finish the list—subsection 85.2(1), which was carried, and we were then discussing the Liberal amendment, which is identical to the government amendment that we had just passed. The two being identical, we will not deal with the Liberal amendment.

**Mrs Sullivan:** On a point of order, Mr Chairman: I think that the parliamentary assistant is right to show some hesitation, because the amendment which the committee passed to section 18 of the bill, subsection 85.1(4) of schedule 2 to the act, isn't an amendment, and

we were moving rather quickly and carried it anyhow. It reads, "The government intends to recommend that the committee vote against subsection 85.1(4)."

**The Chair:** Mr Wessenger, I'll allow—

**Mr Wessenger:** Yes. What I suggest we do is—we haven't actually passed any of these, 85.1 or 85.2 or 85.3; we've just passed amendments to them. So I'd like to go back to 85.1, and I would ask that we deal with 85.1(1) to (3) as a single vote and then deal with subsection (4) as another vote and subsection (5) as a separate vote.

**The Chair:** Okay. Could we just deal with the last two amendments first, and then I'll entertain that discussion.

**Mr Wessenger:** Okay.

**The Chair:** All right. We have two government amendments. First of all, government amendment to section 18, section 85.3. Shall the government amendment carry? In favour? Opposed? Carried.

A further amendment, 85.7. Shall the government amendment carry? Opposed? Carried.

**Mr Jim Wilson:** Can we have a recorded vote on that?

**The Chair:** A recorded vote on the—

**Mr Jim Wilson:** Oh, wait a minute.

**Mr Wessenger:** This is not the one you're concerned with. It's the next one, Jim.

**Mr Jim Wilson:** Okay. Carried.

**The Chair:** Carried.

Now, there is a question as to what we have done with subsection 85.1(4), a government amendment, and because of the speed at which we are moving, Mr Wessenger, what did you wish to—

**Mr Wessenger:** What I am suggesting, Mr Chair, is that we've not really passed any of these sections in total yet. We've just merely passed amendments, so we can legitimately go back and pass them as sections.

First of all, I'm requesting that when we deal with 85.1, that we deal with 85.1(1) to (3) as one item, subsection (4) as a second item and subsection (5) as a third item. The reason for this, if I might indicate, is that one of the subsections the government would like to vote against.

**The Chair:** Okay. Does everyone understand what we're about to do?

**Mr Jim Wilson:** Yes, but I don't agree.

**The Chair:** The Chair will just take a moment to consult. We'll just have a brief recess while we look at this.

*The committee recessed from 1713 to 1716.*

**The Chair:** Thank you, members. Under the motion to the House, the Chair is directed to put the questions as he deems fit. There is a problem which is the fault of the Chair, in that there was not an amendment, and I called an amendment which in fact did not exist and should not in all probability, quite frankly, have been included in the body of amendments. So my ruling is that we will deal then and vote on each of those sections and that is how we will deal with it, but that should not have been shown

as an amendment. That being said, if members would just bear with us, we will then go to section 18.

Shall subsections 85.1(1) and (2), as amended, carry? Carried.

Shall subsection 85.1(3) carry? Carried.

Shall subsection 85.1(4) carry?

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Okay, a recorded vote. All those in favour?

**Ayes**

O'Neill (Ottawa-Rideau), Wilson (Simcoe West).

**The Chair:** Opposed?

**Nays**

Carter, Haeck, O'Connor, Rizzo, Sullivan, Wessenger.

**The Chair:** That is lost.

Shall subsection 85.1(5) carry? Carried.

Shall section 85.1, as amended, carry? Carried.

Shall subsection 85.2(1), as amended, carry? Carried.

Shall section 85.2, as amended, carry? Carried.

Shall section 85.3, as amended, carry? Carried.

**Ms Christel Haeck (St Catharines-Brock):** Mr Chairman, if we follow the same procedure as we did on the previous clause, would you not have to follow with subsections (2) and (3), or did I not hear you correctly? You did 85.2(1) but did you do (2) and (3)?

**The Chair:** Yes. I called all of it.

**Ms Haeck:** Oh, I didn't hear the (3), thank you.

**The Chair:** Shall section 85.4 carry? Carried.

Shall section 85.5 carry? Carried.

Shall section 85.6 carry? Carried.

Shall section 85.7, as amended, carry? Carried.

Shall section 18 of the bill, as amended, carry? Carried.

Shall section 19 of the bill carry? Carried.

Shall section 20 of the bill carry? Carried.

Shall section 21 of the bill carry? Carried.

Section 22, government amendment, shall the government amendment—

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Shall the government amendment to section 22, section 95, carry? Recorded vote, all those in favour?

**Ayes**

Carter, Haeck, O'Connor, Rizzo, Sutherland, Wessenger.

**The Chair:** All opposed?

**Nays**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** The amendment is carried.

Shall section 22, as amended, carry? Carried.

Shall section 23 carry? Carried.

Shall section 24, the short title, carry? Carried.

Shall the long title carry? Carried.

Shall I report the bill to the House? Agreed.

We have therefore dealt with Bill 100. Just before  
adjourning, I would like to thank all of those who

supported the committee in its work. The committee  
stands adjourned.

The committee adjourned at 1723.







## CONTENTS

Wednesday 8 December 1993

**Regulated Health Professions Amendment Act, 1993, Bill 100, *Mrs Grier* / **Loi de 1993 modifiant la Loi sur les professions de la santé réglementées**, projet de loi 100, *M<sup>me</sup> Grier* . . . . . S-689**

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York North/-Nord L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- \*Carter, Jenny (Peterborough ND)
- Cunningham, Dianne (London North/-Nord PC)
- Hope, Randy R. (Chatham-Kent ND)
- Martin, Tony (Sault Ste Marie ND)
- McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)
- \*Owens, Stephen (Scarborough Centre ND)
- \*Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Haeck, Christel (St Catharines-Brock ND) for Mr Hope  
Sullivan, Barbara (Halton Centre L) for Mr McGuinty  
Sutherland, Kimble (Oxford ND) for Mr Hope and Mr Owens  
Wessenger, Paul (Simcoe Centre ND) for Mr Martin

#### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Wessenger, Paul, parliamentary assistant to the minister  
Henderson, Christine, legal counsel  
Schwartz, Ella, policy analyst, professional relations branch

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Schuh, Cornelia, deputy chief legislative counsel



C72011  
XC12  
S77

S-28



S-28

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 13 December 1993

# Journal des débats (Hansard)

Lundi 13 décembre 1993

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Organization

Organisation

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 13 December 1993

The committee met at 1544 in room 151.

## ORGANIZATION

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. The standing committee on social development is meeting for the purpose of organization. There are two matters that we need to deal with.

We will be having a bill, probably Bill 119, the tobacco bill—I always forget the numbers but I think that's the appropriate number; it is—An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others.

That hasn't been officially sent to us but I think it's safe to say it will be. I'd like to get a motion that would allow the subcommittee to take the necessary organizational steps.

**Mr Jim Wilson (Simcoe West):** I move that the social development committee authorize the Chair, in consultation with the subcommittee on committee business and, when time permits, with the committee, to make all arrangements necessary for committee hearings on any legislation and/or subject matters that are or may be referred to the committee for consideration during the

winter recess. I will submit that to the clerk in writing.

**The Chair:** Thank you. Any discussion? All those in favour? Carried.

The second item where I need the committee's approval is that the subcommittee will work out our time schedule and so on, but we do need to approve an advertising budget in the event that we need it. The advertising expenses, assuming that we were doing the normal across the province, and I assume we would be in this case, is approximately \$20,000. I seek the committee's approval for that expenditure, subject to the subcommittee so directing.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I so move, Mr Chair.

**The Chair:** Thank you, Mrs O'Neill. All those in favour? Opposed? Carried.

I believe that is all of the business that we need to deal with, if I could just meet with the subcommittee briefly. The standing committee stands adjourned until the call of the Chair.

The committee adjourned at 1546.



## CONTENTS

Monday 13 December 1993

<b>Organization</b> .....	S-701
---------------------------	-------

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

\***Chair / Président:** Beer, Charles (York North/-Nord L)

\***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gardner, Dr Bob, assistant director, Legislative Research Service

C170  
X22  
577



S-29

S-29

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 31 January 1994

# Journal des débats (Hansard)

Lundi 31 janvier 1994

## Standing committee on social development

## Comité permanent des affaires sociales

Tobacco Control Act, 1993

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 31 January 1994

The committee met at 1307 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. I call this session of the standing committee on social development to order. We are to begin today examining Bill 118, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others.

Our schedule this afternoon at the opening of the hearings will be to hear from the minister and to have a technical briefing on the bill. As you can see from the agenda, there are two organizations that will also be appearing this afternoon, the Physicians for a Smoke-Free Canada and the Ontario Restaurant Association.

With that, I invite the minister to make her opening presentation.

## MINISTRY OF HEALTH

**Hon Ruth Grier (Minister of Health):** Thank you very much, Mr Chair. I'm glad to welcome the committee members. This is the first day of hearings and I guess the first hearings in the new year. I will, as you've said, be making the opening statement. My parliamentary assistant the member for Durham-York will be carrying the legislation in committee after that.

I have with me here at the front Brenda Mitchell, who is the manager of the tobacco strategy unit. Then the technical briefing that follows will be given by John Garcia, who's the director of the health promotion branch; Frank Williams, legal counsel; and Dr Richard Schabas, chief medical officer of health, who are all here at the moment.

It's Bill 119, which is the Tobacco Control Act. I think you said 118, Mr Chair.

**The Chair:** I'm sorry.

**Hon Mrs Grier:** I'm sure by the time all these hearings are over, it will be 119 firmly engraved in your memory.

It's a very important piece of legislation and we see it as a vital step towards our goal of a healthier society. I therefore welcome this opportunity to appear before the social development committee and make this opening statement.

I look forward very much to hearing the opinions of the members and the presenters on how to make this the best bill possible in order to reach Ontario's goal of becoming a smoke-free province.

The Tobacco Control Act is strong medicine. It

contains tough provisions for tighter control over what we know to be a deadly and damaging substance, our society's leading cause of preventable death.

We know that tobacco costs Ontario over \$3 billion a year in such things as health costs, lost productivity and fire damage.

Let there be no doubt about this government's intention with this bill. We are aiming for effective, far-reaching legislation that discourages people, and especially young people, from becoming addicted to a deadly habit.

During these proceedings you may hear from people who say the bill goes too far. To those people I want to say that the facts about smoking speak for themselves. Those facts argue for the toughest legislation we can produce.

Consider what we know about tobacco use in our society. One of every five adult deaths in this province can be linked to tobacco. That's more than 13,000 preventable premature deaths a year. The fact is that someone in Ontario dies from tobacco use every 40 minutes. The fact is that smoking is a major killer.

There is also convincing research to show that smoking not only harms smokers; it poses a significant risk to anyone exposed to secondhand or environmental tobacco smoke.

Thanks to higher prices and greater education and awareness, the number of people using tobacco has declined dramatically, from about 41% of Ontarians in 1966 to about 28% in 1990. That's good news.

But there is disturbing new evidence from the Addiction Research Foundation that among teens this downward trend is reversing. The foundation found in a recent study that for the past two years smoking among grade 7 students has increased from 6.1% to 9.4%. That's an increase of 50% and it's an alarming statistic. We believe it's linked to the enormous growth in smuggling and the fact that our children are getting their hands on \$2-a-pack cigarettes.

Twenty-four per cent of Ontario students aged 12 to 19 now smoke. As anyone will tell you, smoking is perhaps the most difficult of all deadly addictions to break.

We must reach young people before they are seduced by this deadly habit. We must reach them with straightforward, factual information that persuades them to make a healthy choice.

We know that if young people do not begin smoking before the age of 20, the chances are good that they will never start, and if they never start, they are well on their way to a healthier life, as well as a life that is likely to be a lot longer.

With this legislation we will make it illegal to give or sell cigarettes to anyone under 19.

We will outlaw the sale of tobacco in pharmacies and

other health facilities.

We will ban the sale of tobacco products from vending machines, a move that supplements the soon-to-be-proclaimed federal Tobacco Sales to Young Persons Act.

With Bill 119 we will require health warnings and other health information as part of tobacco packaging.

We will insist that tobacco retailers post health warnings and age limits on their premises.

We will closely monitor tobacco sales with mandatory reports from distributors and wholesalers.

We will ban smoking in designated public places.

Finally, we will provide effective enforcement mechanisms that include fines and bans on selling tobacco for merchants who break the law.

By preventing young people from taking up this deadly habit, we can give them a fighting chance against the many diseases caused by smoking and we can help them avoid other problems such as having babies with low birth weight.

You know about the links between smoking and various forms of cancer, but you also need to know that tobacco causes at least 80% of chronic lung disease such as emphysema and chronic bronchitis, and that tobacco is responsible for one third of premature deaths from heart disease.

Since 1970, the lung cancer rate in women has tripled, to the point where it is now a major epidemic. In fact, the Canadian Cancer Society estimates that this year more women will die from lung cancer than from breast cancer. This is all as a result of women starting to smoke 20 to 30 years ago.

How ironic that some of these women fell victim to the seductive messages of tobacco advertising. How tragic that they developed a fatal disease because they were told that smoking is a glamorous, sophisticated and essentially harmless pastime.

Anyone who has visited hospitals or cancer centres will tell you that there's nothing glamorous about lung cancer, that there's nothing sophisticated about premature death and that there's nothing harmless about a pastime that kills more than 13,000 of us every year.

Our government's comprehensive tobacco strategy will help us achieve our anti-smoking goals for the rest of this century.

By 1995 we want to make all schools, workplaces and public places smoke-free and to completely eliminate tobacco sales to minors. By the year 2000 we plan to cut tobacco sales in half, to reduce the percentage of teenagers who smoke to 10%, to reduce the percentage of adults who smoke to 15% and to eliminate smoking by pregnant women entirely.

I am very proud of our strategy and I'm proud that Ontario is leading the country in efforts against tobacco use. We have won international acclaim for our stand on smoking.

As members may know, Nova Scotia, Newfoundland, New Brunswick and British Columbia have recently passed their own tobacco legislation. As I have mentioned, new federal legislation will be coming into force

later this year. But there's no question that Ontario is leading the way in this area. We have set our sights on tough targets and we are taking aim against a deadly foe.

In December, the ministry launched a powerful and provocative public education campaign against smoking. We are spending \$3.15 million this year on a program to reach young children, teens and their parents with key anti-smoking messages and material. This program complements the efforts of health professionals and volunteers across the province who are also working to prevent smoking.

Our cinema ad which some of you may have seen over the holidays, the one known as Swimmers, began running in movie theatres across Ontario in December. It has been followed by equally powerful television spots. Other components of the campaign are now hitting newspapers, buses and subways as well as radio stations.

The response to this campaign has been strong and immediate. One mother called to tell us her teenaged daughter's two friends actually quit smoking after watching our ad on TV. In movie theatres, audiences have applauded and even cheered our commercial.

We recently launched the first part of our parent campaign with a booklet, *Talk it Out*. The booklet is designed to help parents discuss smoking with their children. After promoting the booklet in local newspapers for two days, the ministry received requests for some 7,300 copies of *Talk it Out*.

Throughout the committee process, I welcome and will respond to any issues and questions that are raised. During the second reading debate, there were concerns raised, especially around the sale of tobacco in pharmacies and the ban on vending machines.

Committee members should be aware that the Ontario College of Pharmacists, the professional regulatory body, asked the government to ban tobacco sales in pharmacies. The Canadian Pharmaceutical Association is also on record as opposing the sale of tobacco in pharmacies. Pharmacies are not just another retailer. Like doctors and nurses, pharmacists are health professionals and their stores are an important part of the health care system.

As for the issue of banning cigarette vending machines, the committee must be aware that the pending federal legislation will ban these machines everywhere except in licensed premises. Ontario's legislation simply extends this ban.

It is well known that some children get their cigarettes from unsupervised vending machines. Stricter control of tobacco sales to minors in retail stores will simply make the vending machines more attractive.

Nova Scotia also plans to ban cigarette vending machines and the machines are severely restricted in many places in the United States, including New York City, Minneapolis and the state of Utah.

This government can be proud of its educational efforts, which are backed with significant amounts of money. Today, we are seeking your support for our legislation.

Please bear in mind that we are meeting today in the context of rumours about rollbacks in federal tobacco

taxation. This would be a surrender by Ottawa in the face of apparent inability to control smuggling. The federal proposal to lower taxes on tobacco would create an irreparable tragedy. Thousands of lives will go up in smoke.

My view is that we simply must not surrender. We know full well that high cigarette prices are the main deterrent in preventing children from smoking. Every 10% price increase reduces the number of young smokers by 17%. We also know that the major reason grade 7 children are smoking more is because they have access to smuggled, illicit cigarettes.

1320

Cheap cigarettes will result in needless cancers, heart disease and low birth weight babies. This is too high a price to pay to appease Quebec's smuggling problem.

We therefore appeal to the federal government to reimpose something like the export tax on cigarettes and tobacco products. Remember, in just seven weeks putting the tax back on exports reduced exports by an estimated 60% in 1992.

For our part, we in Ontario expect to enforce more stringent anti-smuggling measures.

The Canadian Cancer Society tells us that tobacco exports have increased from one billion cigarettes in 1989 to nearly 15 billion in the first nine months of 1993. The Canadian Cancer Society report says Canadian manufacturers made nearly \$100 million last year in this market. I am deeply shocked by the recent news reports alleging links between the industry and the smuggling trade. These allegations demand immediate investigation by the federal government. It's time to pull back the curtain and see who is really running this show.

I think we must also ask cigarette manufacturers and their shareholders to search their consciences. We need to ask them what additional measures they can take to deter smuggling. What can they do to make cigarettes less appealing to our children, and do they really want their children to smoke?

This committee has, in Bill 119, an opportunity to make a real difference, one that will bring more lasting benefits to this province than almost anything this Legislature has been asked to do.

I look forward to the cooperation of all members in securing the speedy passage of this bill so that we can take a giant step forward to a healthier Ontario.

I would like to conclude my remarks here today by quoting from a report by Dr Richard Schabas, Ontario's chief medical officer of health, who said:

"Tobacco-related diseases are this province's number one public health problem. The cost in human lives, quality of life and health care dollars is colossal. The circumstances call for nothing less than thorough and relentless action by all Ontarians."

Bill 119 is a vital step toward taking that action. Bill 119 puts it in our collective power to prevent death and disability for thousands of people in the years to come. By doing so, we will also be protecting our health care system for generations to come.

By passing this legislation, you will be earning the gratitude of your children and of their children and you will be helping Ontario set a standard that others will be eager to follow.

**The Chair:** Thank you very much, Minister, for the presentation. We are going to be receiving a technical briefing as well, but I would like to invite the two opposition critics, if they want to make comments now, to feel free to do so, or if they wish, to wait. Would you like to make some opening comments?

**Mr Dalton McGuinty (Ottawa South):** Yes, I would like to do that.

Minister, let me begin by congratulating both you and your government for bringing this bill forward. You will know that I have taken a personal interest in bringing measures forward. I brought forward a private member's bill, Bill 118, and I have an interest, of course, in particular in ensuring that we make it harder for our children to start smoking.

One of the things I learned in the course of my research for my bill was that the response was virtually unanimous if this question was asked: "Do we want our children to smoke?" I found that when I asked that of tobacco farmers, manufacturers, smokers, non-smokers, everyone agreed.

When we stray beyond that is when we get into areas of controversy. You mentioned a couple of areas of controversy yourself. One of those has to do with the ban on the sale of tobacco products in our pharmacies. It is my understanding that this will not reduce tobacco usage one iota. There are as I understand it some 2,200 drugstores in the province and 1,500 sell tobacco, but there are 120,000 other retail outlets which sell tobacco products.

My research, some of it anecdotal, led me to understand that the sale of tobacco products in pharmacies was, by and large, better supervised than it was in a local convenience store. The kids I spoke to generally didn't buy from a pharmacist.

The other issue related to this problem with the tobacco sale ban in pharmacies is that I believe there's a constitutional issue here and I look forward to hearing from some of the presenters in that regard. The issue there is whether it is constitutional to prohibit the sale of tobacco products in one retailer only. I think it is one thing to say, for instance, that we're going to sell all of our liquor products at the LCBO and our beer products at The Beer Store, but it's another thing to say that everybody can sell tobacco products except for these people. Another argument that could be made in a rather compelling way is that tobacco is a drug, and if we are to restrict its sale, it should be to drugstores.

The other thing we have to keep in mind is that it's 1994 in Ontario and there's a recession under way, and we have to worry about the economic impact of any kind of legislation we pass here at Queen's Park. Pharmacies are small businesses. They pay taxes, employ people, pay for heat and hydro, their phone, their rent. The concern I have, and I look forward to hearing from the presenters in this regard, is what kind of impact this will have on



their businesses. Will we be putting people out of work? That's something we have to take into consideration.)

The problem with tobacco is that it is a legal product. It has been around for a long time and it's terribly addictive. When we respond to the problem associated with the health care problems, we should do so with some understanding of the history of this product and of the industry that we have encouraged over the years to grow up behind it. We have generated significant revenues. We have profited from cigarette sales in this province for years and years. It's important to bear that in mind.

The federal government, as you indicated, Minister, has decided to deal with the vending machine problems by providing that they can only be used in licensed premises. I think you're quite right about addressing this issue of vending machines, because one of the things I found out is that if you don't clamp down on vending machines, kids who can't get them at the local store will get them at the vending machine. But I wonder if it isn't reaching too far by prohibiting those machines within licensed premises.

Again, we have over the years in a number of ways told the people here that they can feel free to smoke. It's becoming more difficult of late, of course, and I think rightly so, but there are a lot of people who enter these licensed premises and have a drink, and a lot of people who have a drink want to have a smoke. It's something we have to keep in mind and consider as we deal with this issue.

One of the concerns that was raised with me was that people put in their eight-hour days and at the end of the week they go out to a bar—and we profit, of course, from the money they spend on the booze there—and now we're telling them that they can't get their smokes at the bar. The concern that was raised was that now we're going to put them out in their cars. You can't get them inside the bar. You drink, you smoke; a lot of people tell you they go hand in hand. Now we're going to say, "Get out of the bar to go get your cigarettes, because you can't get them in here." We don't want to encourage somebody to get out there and drive after they've been drinking in order to go buy their cigarettes.

Those are some of the issues. We look forward to hearing from the presenters along the way here.

Minister, you raised this very important issue dealing with how the feds are going to react with respect to the black market sales of cigarettes, and it will be interesting to see how your government is going to respond. I don't envy your position; it's very difficult. I'm glad to see you are coming out strongly against decreasing the taxes. I hope your government will be able to hold the line in that regard.

1330

I should mention that as my party's native affairs critic, I've also had the opportunity to visit the band at Akwesasne. You should know that the leadership there has been calling for more than five years now for the federal government to place a limitation on the number of cigarettes that are being routed and rerouted through the

States back up here. Americans don't smoke Canadian cigarettes. The government has been woefully blind, as have our manufacturers, to the fact that we're sending a lot of cigarettes down there which are simply being rerouted back up here through the reserve and into the hands of willing smokers throughout the province.

Those are my comments for now. I have some questions for the technical briefing, and I'll leave it at that.

**Mr Jim Wilson (Simcoe West):** On behalf of my caucus colleagues and myself, I want to thank the minister for her comments this afternoon. I think it best at this time to yield the floor to my colleague Mr Norm Sterling, who has a long and distinguished career with respect to this issue. Mr Sterling wants to impart some wisdom to this committee, and I welcome his comments.

**The Chair:** Mr Sterling, we welcome you and your wisdom.

**Mr Norman W. Sterling (Carleton):** My wisdom hasn't been welcomed too many times. All of us here should realize that somewhere between 30 and 40 people are going to die in our province today prematurely by seven or eight or 10 years because they have been smoking. If we had heard today that there was an accident on Highway 401 where 35 people had perished, that would be front-page news in every daily in this province. Yet that's happening day after day, every day of the year.

In 1975, the World Health Organization recognized smoking as the single most advantageous health matter that governments could undertake to discourage. In other words, of all the health hazards we have in the world, if people stopped smoking, that would be the single most positive thing we could do.

In December 1985, long before this issue became a popular political issue, I introduced a bill in this Legislature that advocated controlling smoking in the workplace and in public places. Subsequent to that and during the last Liberal government, I introduced six or seven other private member's bills, including such measures as the licensing of vendors to sell cigarettes, allowing municipalities to make more extensive bylaws in controlling smoking in the workplace and a number of issues, some of which are covered in this particular bill.

Only in 1989 did the last government take some action and introduce legislation dealing with controlling smoking in the workplace. Quite frankly, I had hoped that the present government, when it came to this issue, would tighten up some of the looseness which surrounds that legislation, although I will admit, and I think as a result of that legislation, that smoking has been banned by many employers in their workplaces, notwithstanding the relative weakness of the existing legislation.

I am happy to see in Bill 119 that the province will be making some law surrounding smoking in public places. Heretofore, we have only had municipalities making various bylaws across this province, and therefore there is no consistency when one crosses the border from one municipality to the other municipality.

It's interesting that an issue like this can get embroiled in politics. I can remember introducing an amendment to the bill on controlling smoking in the workplace in 1989

under the former Liberal government. My amendment came down to the most basic concern I had about smoking in the workplace, and that was smoking in a nursery school. My final amendment was that we should not allow any smoking in a nursery school or day care centre, because young people, as you know, Madam Minister, have much less tolerance to secondhand smoke than adults because of their size.

The majority government of the day defeated that amendment. I knew then that even though this is an issue which coalesces everyone in terms of dealing with it—I hope and I trust these hearings will be constructive and not come down to the petty politics that were practised in the Legislature that day.

I believe we around this table have a common goal of trying to discourage all people in Ontario from smoking, particularly our younger people. The question for Bill 119, of course, is whether it will achieve this end. Will it help in some way? Will all the measures outlined by you help in some way?

I believe that most of them will and therefore, as my caucus has indicated before, we support this legislation. But we must continue to look at each issue and say: "Will this really help? Is it unnecessary regulation? Will it be more costly? Can it indeed lead to the opposite result of what we are trying to achieve?"

One of the concerns on the front pages of the papers at the present time is the whole area of tobacco taxes. As a politician, both as a minister prior to 1985 and as an opposition member—probably the only opposition member in this Legislature I know of who has ever stood up to a Treasurer and said, "Please increase taxes." I said that on the record a number of times during the latter part of the 1980s. I said, "Mr Treasurer, increase taxes on tobacco," because I was convinced and remain convinced that the higher the price of tobacco, the less likely consumers are to take up the habit, particularly our young people. I base that on some studies I believe were done in Michigan.

The question that political leaders have to face at the present time, both provincially and federally, because there is tobacco tax at both levels, is that as a result of the level of taxation we have reached at this point on tobacco and the relatively lower level of taxes in the United States, whether our young people are getting the cheaper tobacco now in greater numbers than those who are abiding by the law and buying Canadian cigarettes that have been properly taxed.

If we have created a situation in this country which we cannot enforce, then the political leaders are going to have to try to find some kind of solution if we cannot stop these illegal sales of tobacco. I hope that is not the answer, but we must be realistic because we are very, very concerned that our young children, young teenagers, are buying cigarettes out of the back of a truck adjacent to their school yards, which I have heard many stories of.

I think too that one thing that has not been addressed by our government—and I'm going back prior to 1985 and to the next administration, the Liberal government and to the present government—is dealing with our tobacco farmers, our tobacco producers, those people who

make the cigarettes and the communities those tobacco farms support.

I have urged on many occasions in the Legislature that the government dedicate at least a portion of the tobacco taxes to buying these farmers out of producing tobacco. It is my belief that as long as we continue to have tobacco producers in our province, the large manufacturers will continue to use them as their political tool to continue their fight to keep smoking at the forefront and put forward the whole idea that we are benefiting from the producing of tobacco. Even if we could reduce our tobacco industry to producing tobacco for foreign markets, I don't buy that we should in Canada be exporting this dreadful addiction.

#### 1340

Therefore, I urge this government to consider in its budget dedicating part of the tax to buying out our tobacco farmers, to retraining our workers in the manufacturing sector who are producing tobacco products and to helping some of these communities readjust. It's long overdue, and as soon as we get rid of that basic part of our tobacco industry, we will no longer have the exploitation of these producers to put forward the tobacco manufacturers' cause.

We are concerned in our caucus about a number of matters dealing with this bill. Number one, of course, is whether the measures in here are really going to do some good. We look forward to actually improving the bill if we can discover through the witnesses whether there are other matters.

We are concerned about the provision restricting pharmacies from selling tobacco. I must say that it's not unanimous in our caucus. As you may know, we have had a number of opportunities in the Legislature to vote freely on various matters. I imagine, if there was an amendment that came forward in the Legislature during committee of the whole, you would find a variance within our caucus on this issue.

On the one hand, part of our caucus is saying that it's not necessary for us to intrude in this area as a government, that perhaps the pharmacies themselves, on their own moral grounds or on their own business practice grounds, should be making those kinds of decisions and government should not be involved in them. I have some attraction to that because I am concerned, as we go through the regulation of businesses, that we don't step in unnecessarily, as they have so many other restrictions that go around them.

On the other hand, I was the only MPP who sat with the pharmacists' group at the media studio here about a month ago, when it brought forward its view that it wanted it excluded from the pharmacies. I understand their college has approved this. But on the other hand, I don't know whether it's the college that should be putting forward something like that, whether we should be giving the college the power to restrict its own people, or whether it should be the government that should be doing that. I'm very concerned that we not step in when it's not necessary.

On the vending machines, it's my understanding that



under the law which exists today, the government could virtually shut down vending machines, as the law stands. All it would take is for a person under age to operate that vending machine once and the owner of that vending machine could be charged. No government has ever taken this stand and in fact, I don't know that there has ever been a charge laid by any government over the sale of cigarettes to younger people from vending machines. Therefore, I really believe this could have been done without legislation if the minister had so desired.

It's a good step to do away with vending machines where they are accessible to young people, because of the uncontrolled nature of the sales transaction. I do think, however, that when government steps into a situation like this, compensation issues for those people who own vending machines should also be considered. If governments dramatically change the rules for a business, then there has to be some fairness in dealing with that business owner.

My colleagues and I look forward to a very constructive set of hearings. As I say, we will look forward to improving the legislation, trying to find accommodations to deal with all of these matters, and indeed strengthening it where we think stronger measures can be taken where results can be shown to be beneficial as a result of those measures.

**Hon Mrs Grier:** Let me respond very briefly, because I suspect that all the issues and questions that have been raised are ones that the committee is going to hear both sides on at great length in your hearings.

I did want to touch on a couple of remarks Mr McGuinty made about the better supervision of the sale of tobacco in pharmacies, just to say that there is really no evidence that in fact that is the case. The pharmacist as a health professional is frequently at the back of the store and the tobacco is sold at the counter at the front. I'm not aware that there is any intent or any effort made by the pharmacist to counsel those who come to purchase tobacco about the evils of so doing, so I don't quite accept that reason for not banning the sale in pharmacies.

The other point I wanted to make was with respect to bars. While the vending machines are banned, there is certainly no reason the cigarettes could not be sold from behind the bar. Our reason in looking at the federal legislation's ban on vending machines in licensed premises was that in Ontario, licensed premises are quite often family restaurants where the vending machine is in the lobby and then there's the door into the restaurant, so the accessibility to young people is very real. We didn't feel that even letting them remain in licensed premises was going to achieve our objectives.

As Mr Sterling has pointed out, it is very important that we have legislation that really achieves the objectives and that will work, so in response to him, let me say that I hope the debate will be constructive and I certainly am open to ideas about how we can make the legislation better, more enforceable and make sure it does achieve our objectives, particularly in light of the rumours about contemplated federal action.

I suspect that by the time you've finished your deliberations, we will know whether the federal government is

going to move on reducing taxes. Should that be the case, it may well be that the committee will have some suggestions of changes to this legislation that would enable us to counteract the very damaging effect of that federal action. If we had to look at more stringent prohibitions or restrictions with respect to packaging or something that could help us counteract that effect, I would certainly be open to that kind of discussion.

I know you have a large number of presenters lined up to appear before you as you travel, and I also know that the member for Durham-York, who has taken a very active role in bringing us to this point on this legislation, has all the answers to all the questions that may be posed. I leave you in good hands.

**1350**

**Mr Jim Wilson:** While the minister is with us, I reflect back to the press conference you held here in the building when launching this initiative, this legislation. You were asked the question whether or not you had any studies to indicate that banning the sale of tobacco products in pharmacies would decrease the number of people smoking, particularly young people. At that time, you admitted you had no studies. I wonder if the ministry has done any studies in the meantime to show that this initiative would actually have an effect in decreasing the number of people who smoke.

**Hon Mrs Grier:** The studies that have been done clearly indicate that a limitation on the number of outlets decreases the use of cigarettes, but whether pharmacies as opposed to limiting it in some other kind of establishment—I'm not aware of completion of any of that work, but as part of the technical briefing, you may well be able to get more specific information on that from the officials.

**Mr Jim Wilson:** Unless something popped up over Christmas, your department doesn't have any studies to show that this particular initiative in this legislation will, as Mr Sterling pointed out, be beneficial to society as a whole.

My second question is, if the federal government were to lower the federal tax on tobacco products, are you recommending to your Treasurer that he increase the provincial tax and hence the net effect on taxation would be nil?

**Hon Mrs Grier:** The Minister of Finance is part of a committee that the federal government established between the government of Quebec, the government of Ontario and the federal government looking at measures to deal with the smuggling problems. Our position is very clear that we oppose the lowering of taxes. We have not had a conversation around what actions Ontario could take in the event that the federal government moved, because it is our very earnest hope, supported by a growing number of health groups all across the country, that that not take place. I was delighted to see the federal Minister of Health supporting that position recently, so it's a hypothetical, we hope, situation at this point.

**Mr Jim Wilson:** Can I flush you out a little bit more on your smuggling position? In the Legislature, you've consistently told us it was a federal matter, that the



federal government had to deal with it. Now the federal government is letting us see some of its cards in a preliminary way with respect to the taxation matter. It's coming forward with a suggestion to the public, floating that idea anyway, and then all you say is that it's a terrible idea. Have you got any ideas of your own with respect to solving the smuggling problem?

**Hon Mrs Grier:** I'm sure you're aware of the submission the Canadian Cancer Society made to all governments with a whole list of proposals for better enforcement. The status of the proposals from the federal government appears to be somewhat unclear. When they first appeared, it was that this was a proposal. I think the Minister of Finance federally has now said no, that this has not been a concrete proposal put before the tripartite committee. I think we have to wait until that committee has finished its decisions and we know where the federal government is going before I could comment on it.

**Mr Jim Wilson:** It's been suggested to me that your government really doesn't particularly like pharmacists, and that's something that I think has shown through very clearly in a number of policies you've brought forward, in the past year in particular.

Along that line of thinking, it's been suggested by pharmacists that perhaps your government feels there are too many pharmacies in the province—you haven't got any proof to show that it will improve the health of the population by banning the sale of tobacco products in pharmacies—and that perhaps the intent of that section of the legislation is to just get rid of some pharmacies in the province because you think there are far too many.

We know you want to decrease access to certain parts of the health care system and to bring down costs. For instance, you've just said your belief is that if there's less access to tobacco products perhaps that will bring down consumption. Then I guess if there's less access to drugs for seniors, that may bring down consumption of prescription drugs by seniors. What do you have to say with respect to the charge that perhaps this particular section of the bill is really part of the greater plan to simply put some pharmacists out of business?

**Hon Mrs Grier:** What I have to say is that I find that absolute suggestion offensive. Any suggestion that we would be trying to deny people access to medications they require I categorically reject, as do I your suggestion that we do not support pharmacists.

In fact, the suggestion that pharmacists not be allowed to sell tobacco came from them as a self-regulating body through the Ontario College of Pharmacists and was largely a result of a large number of pharmacists, and I know you will hear from them, who have themselves decided to stop stocking tobacco products and who believe they would like, as small business, a level playing field with their competitors.

In fact, we regard pharmacists as health care professionals. All our efforts with respect to the health system have been to allow pharmacists to use more effectively their extensive training in the dispensing of pharmaceuticals. We talk to them about better methods of reimbursement for their pharmacological skills, as opposed to being paid merely for the dispensing of

prescriptions. There is now no incentive for a pharmacist not to fill a prescription because he's only paid if he does fill one.

In working with the profession, we are looking at how they can truly fulfil their training and their role as health care professionals, as opposed to merely being dispensers of tobacco products. I know you will hear very strongly from them when they appear before this committee that they regard themselves as health care professionals and part of the health care system and wish to be able to function as such.

**The Chair:** We're going to take a brief three- to five-minute recess so we can set up a screen that's going to be used in the technical briefing. If people who are going to be doing that briefing could get their material and equipment ready, we'll take a five-minute recess.

*The committee recessed from 1355 to 1402.*

**The Chair:** We'll reconvene the standing committee on social development, and I'll get it right this time: We are examining Bill 119, not, as I had suggested earlier, another number.

Before beginning the technical briefing, I would ask our researcher, Bob Gardner—there are just a few he has circulated—to make a few comments.

**Mr Bob Gardner:** Members will know that we distributed a background package last week and we had a set of material in there on federal issues, much discussed by the minister and the critics today, of course.

We did another package, which was just put on your desk now, of articles over the weekend on the federal discussions from last week. Members will know that in some of the newspaper articles there was a reference to a new federal strategy paper. We spoke to ministry officials in Ottawa and no such paper has been formally released. We'll keep looking at that, of course, and get it for you as required. This is simply a number of articles from over the weekend on the issue.

**The Chair:** Thanks very much. We'll now move to the technical briefing. The parliamentary assistant is with us. I wonder if you would be good enough to introduce representatives from the ministry who are going to be with us, and then I'll turn it over to you.

**Mr Larry O'Connor (Durham-York):** Before us we have the chief medical officer of health for the province of Ontario, Richard Schabas. I suppose a lot of the committee members remember this report that was put out by the chief medical officer some time ago and I'm sure he's going to highlight that. It looks like a slide there before us from that report.

We also have Frank Williams here, from legal services, who will help us with legal advice through this process, and of course John Garcia, who is the director of the health promotion branch. I think we've got some very able people here to give us a very good briefing.

**Mr John Garcia:** We had planned the technical briefing in three parts. We thought we would begin first with an overview of tobacco use as a public health problem. Dr Richard Schabas, the chief medical officer of health, will present that briefing.

Then I will give a very short overview of the comprehensive tobacco strategy which is being implemented now by our ministry in conjunction with other ministries. The minister touched on many of the points I would make, so I'll keep that presentation quite brief.

This will be followed by a review of the bill. Brenda Mitchell, the manager of the tobacco strategy, is also here and she will take you through the bill clause by clause, provide a very brief description of what is included and a brief rationale for each clause. As Larry mentioned, Frank Williams, the deputy director of legal services in the ministry, will be happy to answer any questions on the legal side.

**Dr Richard Schabas:** I'm Dr Richard Schabas. I'm the chief medical officer of health for the province of Ontario and the director of the public health branch in the Ministry of Health. My role this afternoon is to very briefly review the issue of tobacco from a health standpoint.

As Mr O'Connor has already pointed out, there is the tobacco report, which is tab 23 in your binders, so I'd invite you all to review that. Some of the slides I'm going to show this afternoon are taken from that report. In addition, I released a report in 1992 dealing with adolescent health issues, which included tobacco. That's tab 24 in your binders.

Furthermore, my 1993 report, which looks like this, called *Promoting Heart Health*, also deals in some measure with tobacco. Unfortunately, the demand for this report has exceeded supply, so I don't have additional copies today, but I will make them available to the committee. Again, some of my slides today are borrowed from that report. I'd invite you to read those reports. They have a lot more detail than I'm going to go into today. I'm not going to repeat all the information that's in there.

What I'd like to spend my few minutes doing, though, is highlighting what I think are some of the really key points about tobacco use from a public health standpoint. In particular, I want to look at the magnitude of the problem, why it is we get so much more excited about tobacco than we do other health hazards. I want to focus in on why adolescents are such a key target group in the battle against tobacco. Then I'd like to draw some lessons from our experience in this province over the last 20 years to show where we have been making progress and also where we have not been making progress.

Let me begin by looking at the magnitude of this problem. It's easy to get a little cynical, because on an almost daily basis we're bombarded with information about health hazards. It's either chemicals or it's something we eat or perhaps it's sunlight, but on an almost daily basis, we learn about something new that's bad for us. I think there's a tendency sometimes to lump them all together as being equally important. From a public health standpoint, tobacco is important because it stands alone, far and away the most important identifiable health hazard we're faced with in this province, in this country.

This slide is meant to illustrate that. This is a graph which shows the number of deaths per year from tobacco use in Ontario compared to three other important causes

of death: traffic accidents, suicide and AIDS.

The purpose of the graph is not to suggest that traffic accidents, suicides and AIDS are not important public health problems, as they most certainly are, but to demonstrate just how much more important tobacco use is. You've heard the numbers, more than 13,000 deaths per year. That's the equivalent of Niagara-on-the-Lake or Kirkland Lake. It's an almost unimaginably large number of people. Maybe one of the problems is that the numbers are so large that we've become somewhat immune to the real horror of what tobacco does to our population.

Furthermore, I'd like to emphasize that this is a graph that shows deaths, but deaths are really only the tip of the iceberg in terms of the health impact of tobacco, because where there are deaths there is also disease, there is also suffering, there is disability, there is also lost income. There are important costs here. There are health care costs. Tobacco-related disease is an important burden on our health care system and there are other costs of lost productivity estimated in total as being in the area of \$3 billion per year in this province alone.

This rather grisly slide is meant to make the point that tobacco affects health in many different ways. These are some of the key diseases that are related to tobacco and they're in the proportion of the number of deaths that can be linked to tobacco use. I think the slide's important because there's generally good perception about the link between smoking and lung cancer and smoking and chronic lung disease. But what very few people realize is that the biggest impact of smoking on mortality, on deaths in this province, is not through either of those diseases, it's through heart disease. Smoking is an important contributor to ischemic heart disease, to heart attacks and the many deaths that are caused by that condition. Smoking is a major cause of that and, as the graph shows, that's where the biggest total impact occurs.

#### 1410

It's also spread through stroke. It contributes to other cancers, cancer of the larynx, cancer of the oesophagus, the stomach, the pancreas, the urinary bladder, to name a few.

What this slide doesn't include are other important health consequences. Careless smoking is the leading cause of house fires and deaths associated with house fires. It's the leading preventable cause of low birth weight infants in this province. The list goes on and on.

The point here is to understand the scope of the health impact of tobacco. If we relate it to our own lives, it's very easy for us all to identify how tobacco-related diseases of these kinds have touched the lives of everyone.

This is basically the same as the last one, so I'll skip over it.

This is, to my mind, the most striking graph, the most striking visual I've produced in any of my chief medical officer of health reports. This is a graph that illustrates the epidemic rise in deaths from lung cancer in women in Ontario from 1970 to 1990. The minister has already related the three-times increase, but I think it's only when you see it portrayed visually that you get some sense of



the importance of the dramatic nature of this increase.

In fact, if we follow that line back 20 years earlier, we would realize that only 40 years ago, lung cancer was a very rare disease in women. By the early 1990s, it is approaching, and in some provinces in this country has exceeded, breast cancer as the leading cause of cancer death in women.

What's particularly tragic about this—let me emphasize again we're not talking about disease rates here; we're talking about deaths—is that this epidemic, and that's not a phrase a public health officer uses lightly, was predictable and preventable. We have had good scientific evidence since the early 1950s that smoking caused lung cancer.

From a scientific standpoint, the landmark report of the American Surgeon General in 1964 resolved that issue: Smoking causes lung cancer. We've known through the 1950s, the 1960s and into the 1970s that the smoking rates in women were increasing. So we knew, should have known, that this was going to happen, yet we allowed this tragedy to occur.

The second point I'd like to make from this graph, one which from a personal standpoint I found very important, is that when we look at lung cancer, which is the major cancer that's attributable to smoking, it's by far the leading cause of cancer deaths in this province. We all have this image somehow that when we get diseases, even serious diseases, we go into our health care system and our health care system has something to offer. We have magic bullets which are going to cure it. Somehow we're going to avoid the consequences of these diseases.

I can tell you that when I was a junior resident in this city studying medicine, it was the frustration I felt in dealing with patients with lung cancer, the inability of all the medical science I'd learned, of all the tools, all the drugs and various things we had at our disposal, the inability to do anything at all for the vast majority of people with lung cancer when we knew what the cause was, that lead to me going into a career in public health.

The sad, tragic fact is that the case fatality rate from lung cancer in this province—that's the number of people who get the disease who subsequently die of this disease—is almost 90%. Almost nine out of every 10 people diagnosed with lung cancer in Ontario will die from their disease, usually within two years of diagnosis.

Furthermore, in spite of a vast investment in research and health care expenditures, those numbers have not improved substantially in three decades. This is a problem that we can predict, that we can prevent. Tragically, we are not very effective at treating it.

Let me turn to the next issue, which relates to why adolescence is so critical. One of the characteristics of smoking behaviour is that people who become smokers almost always become smokers when they're teenagers. A number of surveys have looked at this question, and the estimates vary, but generally between 80% and 90% of adult smokers become smokers by the age of 18 to 20. Beyond the age of 20, very few individuals become smokers. In fact, some studies have shown that up to 50% of adult smokers began smoking by the age of 14.

One of the ironies of all of this is that many adolescents begin smoking because they regard it as an adult behaviour, when in fact the decision to become a smoker is quintessentially an adolescent behaviour. It's children who choose to smoke, not adults. Adult smokers, in fact, spend most of their energies trying to quit smoking.

When we take into account the highly addictive nature of tobacco, the fact that once you become addicted to tobacco it can be very difficult to break that addiction, I think it really allows us to focus our attention on this key age group, knowing that if we can deliver a generation of Ontarians to the age of 20 as non-smokers, we have every reason to expect they will remain non-smokers.

This graph is a good-news graph. What it shows is what has happened to adult smoking rates in Ontario between about 1968 and 1986. Subsequently, we could continue this on down and the rates have continued down, although at not quite such a dramatic rate. What it shows is that we've gone from a time in the late 1960s where almost 50%, almost one in every two adult males, in Ontario was a regular cigarette smoker down to about half that level among adult men. That is a dramatic and important accomplishment.

We can also see from this graph that rates in women have declined over that period of time. They've declined more slowly. In fact, smoking rates among men and women in Ontario are more or less equal right now. There's even some suggestion that women's rates may be creeping up ahead of male smoking rates.

But what this says to me is that smoking behaviour can change. I've said in previous speeches that we don't have to accept it as being like death and taxes. Smoking rates can change. In light of the minister's comments about tobacco taxation, I should say with tobacco it's a question of death or taxes, in which case I certainly would opt for the taxes.

This shows smoking rates among adolescents, among teenagers in Ontario, and again paints an optimistic picture to the extent that smoking rates have declined since the late 1970s, when more than one in every three adolescent males was a smoker, to our current rates which, again, if we followed these lines down to the present, are just a little above 20%. That's an important gain.

The bad news, though—as you can see, the line became quite flat in the 1980s. We made great progress in the early 1980s, less progress in the late 1980s, and we now have the very disturbing evidence from the biennial Addiction Research Foundation survey which suggests that rates have stabilized and that in fact, at least in the very young teenagers, rates may indeed be increasing. I think that's a very strong warning to us that we have to redouble our efforts in this area.

This is another good-news slide. These are figures drawn from the Ontario Heart Health Survey and they show the proportion of Ontario adults by age group—18 through 34, 35 through 64, 65 to 74—who are never smokers. This is the proportion of a generation that are never smokers. As you can see, it's the youngest age group that has the highest rate of never having smoked. A little more than 50% of 18- to 34-year-olds in Ontario



report that they have never been smokers. That's the good news.

1420

The not-so-good news, and again this is drawn from the Ontario Heart Health Survey, which is kind of the flip side of that last slide, shows our smoking rates actually are highest in young people. The 18-to-34-year-old cohort, while it has the largest proportion who never smoke, also has the largest proportion of active smokers. That appears to be a paradox, but it's of course because there's dropout from the ranks of smokers as the cohort gets older.

People drop out for two reasons: First of all, they quit, and millions of people in this province have quit smoking. Also, they die, and that's particularly a factor in the older age groups. So clearly, this is not quite so positive and attractive a picture and let's us know that we have a lot of work ahead.

Finally, this is a slide which is drawn from my heart health report. It deals with more than smoking, but I'm going to ask you to focus your attention on the little campfire, the third from the right, which looks at smoking rates. What this slide does is illustrate one of the other sad facts of smoking in Ontario, that we have inadvertently created quite a marked social and educational gradient in smoking behaviour.

We've gone from a situation 40 or 50 years ago where smoking was primarily an addiction of the well-educated and well-to-do; two out of three doctors used to smoke Camels, according to one famous American ad. We've been very successful in reducing smoking rates among the well-educated and well-to-do, but far less successful among the less well-educated and less well-to-do.

This particular graph looks at educational levels, but similar graphs could be developed for income levels. What that smoking graph shows is that for Ontario adults with at least some post-secondary education the smoking rate is 13%, but for those Ontario adults with only up to secondary school education, the smoking rate is 30%. So clearly we've made gains, but those gains have not been evenly spread across society, and I don't think it's an overgeneralization to say that more and more tobacco use is becoming an addiction of poor women, whereas it used to be one of rich men.

That completes my slides. I'd just like to conclude my remarks by saying how pleased I am to be able to appear before this committee as an advocate for Bill 119, that it's a key component of the tobacco strategy of this government. There are other important components. You've heard about the television ads. I'd also like to remind you that we have a public health program in this province where we have activity and funding for each of Ontario's 42 boards of health to deliver a variety of services, including education, smoking cessation classes, workplace programs and public advocacy, and that in my reports I've called for a number of actions against tobacco. I'm very pleased to see that this legislation addresses some of them. Certainly education continues to be a priority, and the messages on tobacco packages are one component of that.

It's very important that we stop sending young people mixed messages about tobacco. It's one thing to teach them about the health problems of tobacco in their schools, but when they can go out the door and, yes, go to a drugstore, a place that we associate with somewhere you go to buy things that promote health and that treat illness, we're sending young people a very mixed message. I personally believe that's the real crux of the pharmacy issue.

Furthermore, the importance of reducing accessibility, it's well shown, for example, with alcohol, that accessibility is a factor in reducing alcohol use. There's every reason to believe that the same will be true for tobacco. Thank you.

**Mr Jim Wilson:** As critic, I'm very familiar with the work you've done with respect to this legislation and particularly with the reports you've produced, and they're excellent reports. You probably have one of the best illustrators working for you in the government of Ontario, on contract or otherwise.

I have a question with respect to your latter comments. You know my comments on second reading with respect to this legislation in the Legislature and my focusing on the section of the bill that deals with the prohibition of the sale of tobacco products in pharmacies.

It strikes me to ask whether the ministry or anyone has asked young people what their perception of a pharmacy is. It seems to me that adults view pharmacies far more as a place where you seek remedies to a health problem. A young person probably doesn't perceive a pharmacy that way. As a young person, when I was doing science projects, I perceived a pharmacy as a place where you would get poisons, as a place where you would actually have to go ask for things over the counter, my science teacher sending me up to get various concoctions. You know, when you were running the electrodes through little tin pans and that sort of thing, you would have to go get prohibited substances and have your parents sign for them over the counter.

I didn't really have any health problems and therefore never used a pharmacy for any other reason than some science projects, so my perception of a pharmacy would have been a place where I'd go to get prohibited substances, given that in my family we generally bought our shampoos and other health products in the grocery store and didn't go to the pharmacy. Now, I suppose, things have changed to some extent, where the loss leaders are often those general health care items like shampoos and tires and various other things that some pharmacies are into.

None the less, in a serious way, have you interviewed young people and asked what their perception of a pharmacy is, and, along that line, how many young people actually go to a pharmacy to purchase cigarettes?

**Dr Schabas:** I don't know; I can't answer those numbers. It's possible John Garcia can or our colleagues from the Addiction Research Foundation when they come to present to you. Those are very interesting perceptions of how people view pharmacies. I'm not sure I necessarily share them.

You've raised several times the issue of doing research. It's a little unclear to me how you could test the hypothesis of removing cigarettes from pharmacies without actually doing it, and in fact that's the way most public policy hypotheses are tested. But I think you're now raising another issue, perhaps to question young people about their perceptions of pharmacies. Again, I can't comment on that.

I can comment on the pharmacists' perception of pharmacies and the position taken, for example, by the Ontario College of Pharmacists. I'm quite prepared to defer to them in terms of what the perception of a pharmacy is. Their perception of a pharmacy is a place where you should not sell tobacco, for very much the reasons that I identified.

**Mrs Karen Haslam (Perth):** While Mr Wilson will be focusing on the selling of tobacco in pharmacies, I'd like to focus on young people and the health issues around this particular piece of legislation.

One of your charts looked at a decrease of the percentage of people smoking, and I wondered if you had any idea of whether that was in relation to a better education, to taxes, to the sickness involved, to a better marketing of it. I believe it was one on the women, and that really struck me.

**Dr Schabas:** There are two graphs I showed, one of Ontario adults, both men and women, and the decline. The other was for adolescents, which has also declined.

**Mrs Haslam:** I'll get to the adolescent ones later. The first one was the adults. You looked at 1968. There was a marked reduction. Is that in relation to taxes, education, sickness or better marketing of the problems?

**Dr Schabas:** To the best of anyone's knowledge, it's all of the above, the various interventions to deal with tobacco. First of all, they've not been introduced separately. We don't take one measure, stand back for five years and see what happens. A number of things have been going on over that 20-year period: obviously, better scientific information; better education; people became more aware of the health hazards; social attitudes changed, which I think is important; particularly in the 1980s pricing became an issue. There are all kinds of things, and I think it would be an impossible task to try to untangle what contributed to what.

I'd even go so far as to say that probably a number of those interventions were introduced without really good scientific proof that they were going to work. They were introduced more because it was felt necessary to do whatever we could about tobacco and because it seemed to make good sense. It's very hard to untangle which of those were the most effective, but my own judgement is that they probably all contributed.

1430

**Mrs Haslam:** That takes me to your second chart, which was the percentage of adolescents who smoke. The progress in the early 1980s in that chart was phenomenal, which was really great, and then you said that now it seems to be flat-lined. Why was there not a continuation of a decline? Why suddenly in this time period was it flat-lined?

**Dr Schabas:** There are two or three issues I could point a finger at. Again, I can't say definitively what it was. Even among the adults the slope of the curve was sharper in the early 1980s. I think one of the things we did is we were effective at reaching the people whom it was easy to reach. Our main strategy up until the mid-1980s was purely an educational strategy. There are some people who are in a better position to respond to educational messages than others, and it worked for them. We kind of skimmed the cream off the top in terms of tobacco prevention.

I think we got into that problem, that we'd done the easy part and now are faced with the harder part. Particularly with young people in the last two or three years there is real concern that the real price of tobacco has been undermined by the smuggling, and that has played a role as well. We've heard about young people buying smuggled tobacco, something that should make us all very angry. That has been undermining some of the real health benefits which were felt earlier in the decade because of the real price increase associated with taxation.

**Mr Rosario Marchese (Fort York):** I have three questions but we may not have time; I'll ask two that are important to me. You said that in spite of the research we have done in three decades, very little has been shown by way of effective treatment of lung cancer.

**Dr Schabas:** That's right.

**Mr Marchese:** It raises interesting questions. My sense is that we have been probably spending a great deal of money in this field of lung research and I'm wondering, given the lack of effective treatment, whether we should be spending more money in that field as opposed to diverting all of our attention into prevention, reduction, as we're doing, and disusing as the answer.

**Dr Schabas:** I agree with the gist of your point. To be totally fair, there have been advances in the treatment of lung cancer in terms of palliative treatment. People with lung cancer now live longer, by and large, than they did, although most of that extension of life is measured in terms of months, not years. But yes, the point of my comments was to say that, if we look at what is ultimately the bottom line of the treatment of a deadly disease, which is, are we saving lives, the tragic facts are, as I said, that we've not made the progress that I think many of us perceive has been made.

We hardly go a week without reading of some new cancer breakthrough in the newspapers. Unfortunately, when you look at how they add up, at least in the treatment of lung cancer, the final results may not be what we perceive them to be. I agree entirely that, if we want to look at getting the best bang for our buck in terms of research and of health care investment, it's on the prevention side, because that whole graph, that whole epidemic, could have been and should have been prevented.

**Mr Marchese:** I raise this because it's obviously a question we need to ask in many other areas as well. It's the same ethical question we need to address with respect to where most of our health care dollars go. I heard a figure that 60% of our health care dollars go into the



treatment of patients who are in hospitals from six months to one year. Perhaps it's an inflated figure.

These are the kinds of ethical questions we need to address as a society, as to where we spend our dollars, where we spend our research dollars vis-à-vis effective treatment of certain things. That's why I asked you for your opinion in terms of where this leads to.

**Dr Schabas:** These are important questions and I think probably a little beyond the scope of this discussion today, but I quite agree that, particularly as health care resources become scarcer, we have to make some hard and sometimes difficult decisions. But we owe it to our children, if no one else, to put our resources where they'll have the biggest benefit.

**Mr Marchese:** Another question comes to mind in terms of who we are able to reach with our educational programs. Quite clearly, education, class and reduction in smoking are all interrelated, and the ones we're not reaching are the ones who have lower literacy levels. It reminds me of the problem where in the 1900s, the wealthy used to eat the white bread and the working class was eating the fibrous bread, and of course in time the educated class realized there was a problem. So we reversed the situation, where the poor are now eating the white bread and the wealthy are eating the fibrous bread.

**Dr Schabas:** Ischemic heart disease, which is the leading cause of death in Ontario and is related to a number of lifestyle factors, including diet, physical activity and smoking, used to be a rich man's disease. It's not any more. We've completely reversed the social gradient, because it's been the well-educated and the well-to-do who have responded to our health promotion messages.

**Mr Marchese:** So the question for us is, how do we reach those youngsters who come from those particular income levels? Given that education is key and given that our messaging, however we are producing it, quite clearly is effective for those who are able to receive it, understand and then act on it, how do we reach those other young children who are going to have this problem?

**Dr Schabas:** I think you use the tools that work, and the lesson is that education alone is not enough. If education were the answer, then we wouldn't be meeting here today to talk about issues like accessibility, like changing social norms. But that's the key, and that's where I think this particular legislation is particularly strong.

**Mr McGuinty:** Dr Schabas, let me begin by congratulating you on the production of a great report. It's my personal philosophy that one of the jobs of government is to show people how they can better help themselves. Maybe we'll be seeing more and hopefully hearing more from you. You can become the Everett Koop of Ontario medical matters.

Have you got a figure in terms of the costs of the treatment annually for tobacco-related illness in the province?

**Dr Schabas:** There are estimates. I'm quoting from memory here. Dr Bernard Choi from the University of Toronto did a review a couple of years ago of the costs,

and that's where the \$3-billion-a-year figure comes from. I believe, and John or Brenda will correct me if I'm wrong here, that \$1 billion of that roughly—I'm talking in very rough, round figures—was from direct costs of health care and about \$2 billion was lost productivity.

**Mr McGuinty:** What can we do that we're not doing right now to help smokers stop smoking? I understand that idealistically the best way is to create a smoke-free generation. But what about those who are already hooked? What could we be doing that we're not doing?

**Dr Schabas:** I think there are a number of things we can do. Smoking cessation programs, although if you were to study them individually, you'd say that none of them worked, in fact the net effect of a number of them, particularly when people take them repetitively, is that for some people they do work.

The most important factor in smoking cessation is the will to quit. Personally, I believe the biggest factor there is social norms, that what we have to do is continue to reinforce the fact that smoking is just not a socially acceptable thing to do.

I know the clusters of people who gather outside government buildings started some four years when smoking was banned in government buildings, and one of the most striking things—maybe somebody should do a research project on this, maybe we should have thought of this four years ago—is to count how many there are or to count the butts that are out there, because it's certainly my perception that those numbers have declined and declined quite substantially. I think it's because the real benefit of that program was to make it socially unacceptable to be a smoker. That's a little bit of tough medicine for some people, but I think that's what works.

Also, pricing is important. Certainly tobacco smoking is not as price-sensitive a behaviour among adults as it is among adolescents, and we should remember that the real key to pricing as a strategy in taxation is its effect on adolescents, but there still is a curve for adults. Many individuals I've known personally or as patients have finally commented, and I don't know if this is just a rationalization on their part, "I quit smoking ultimately because I couldn't afford to do it any more."

So there are all those and undoubtedly others that I'm not thinking of.

1440

**Mr Ted Arnott (Wellington):** Thank you, Dr Schabas, for all the work you're doing and all the work you will be doing over the next few months.

I'm interested in the issue of the reporting statistics for tobacco use among young people. We see different survey results and so on, and I'm wondering about the methodology that's used, simply based on the belief that a 12-year-old might not admit that he or she smokes. I'm wondering if perhaps these numbers aren't considerably understated.

**Dr Schabas:** Yes. There's no one set of numbers I presented that's perfect in itself for the reasons you pointed out, and also there's a difference in methodology. The Addiction Research Foundation questionnaire is based on, "Have you smoked in the last year?" whereas



questions from the Ontario Health Survey or the Ontario Heart Health Survey looked at regular smoking. So there's a great deal of variation, but what is important are the trends those studies report.

For example, with 12-year-olds in the Addiction Research Foundation biennial study, there are problems. You've identified what the 12-year-olds really tell us, but what's important is to look at the trend in teenage smoking, because there's no reason why 12-year-olds now should be behaving differently, giving different information than 12-year-olds two years ago or four years ago.

Yes, it may underestimate smoking. It certainly, I think, would not overestimate smoking, and it's this latest change in the slope of the curve where it's flattened off and particularly among the grades 7 and 8 where we've now for the first time in 20 years seen an increase in smoking. I find that extremely alarming.

**Mr Arnott:** Do we discourage the use of tobacco in the schools for children, say, age 12?

**Dr Schabas:** The issue within the schools, yes. Smoking is banned in most boards of education in the province, although not in all of them, but the issue I think you're getting at is education of young people.

Indeed, the real focus of the public health program against tobacco use has been in schools and not just in the old-fashioned way of bringing out a black lung. That's what they did when I was in school and we all used to joke about it. It didn't have a big effect. It's using what's called the social influences model, which is basically to try to put smoking in its social context and to give children the defences and the skills to make intelligent decisions.

That's actually something that goes beyond smoking, because obviously they make the same decisions about sexuality and various other important health choices they make, but there's good evidence that those kinds of programs, in the context of general public policies discouraging smoking, can be quite effective.

**Mr Ron Eddy (Brant-Haldimand):** Don't you think that the measures proposed here are going to take too long to do what you feel should be done? Do you feel tobacco products should be banned, that we should face up to the issue and ban tobacco products?

It's something I could face, never having been a smoker of course, but we're going to be faced with more cigarette manufacturers in our country and in our province. Although I understand there's going to be a limit of sales to two cartons per person, I don't know what frequency that would be at the very reduced prices we're seeing in the underground economy.

In view of a tremendously large underground economy where anybody can buy any quantity of cigarettes at any time—I realize we're not able to control, or do we try too hard to even control, crack cocaine or heroin or many other banned products. This doesn't seem to me to really be too effective. Is it too little, too late?

**Dr Schabas:** Clearly, from my remarks and from the position I hold, I would be delighted to see tobacco use disappear from the province tomorrow. It's a question,

though, of introducing measures that are acceptable and will be effective. These things don't change overnight, and the concern would be that if we were to outlaw tobacco products, for example, with 1.5 million Ontario adults addicted to the substance, we would be inviting serious social and other kinds of problems.

I think we have to take the long-term view of this. This is a problem that has been with us in this kind of magnitude for 50 years. We've known about the health consequences, at least relating to lung cancer, for 40 years. I would be very satisfied if we could achieve the targets Ontario set out for itself—10% of adolescents, 15% of adults by the year 2000—and carry it on from there so that maybe by the time I'm ready to retire, we really will be looking at a smoke-free province.

**The Chair:** Thank you. We have other parts of the briefing to continue. We can come back to some of these issues, but perhaps we should go on with this.

**Mr Garcia:** I will give just a very brief overview of the tobacco strategy to comment on the economic cost issue briefly. The Ministry of Health views tobacco use and tobacco control to be a health issue: 13,000 premature deaths every year, one death every 45 minutes, 35 to 40 people every week are simply too many people who needlessly die from tobacco-induced diseases. So we've focused in the main on the health issue because it is such a major public health problem.

We know there's interest in cost information, and Richard did mention a study by Choi. We'd be pleased to provide a copy to the clerk if you'd like a copy of that. It's a bit dated now.

For 1988, about 4.75% of the entire Ministry of Health expenditures was due to the direct cost of physician services and hospital bed use attributable to tobacco-induced diseases. Applying that to the current year, the expenditures on tobacco will exceed revenues in the Ontario coffers from tobacco. So even the economic argument can be made at this point that it's a net drain on the Ontario government and Ontario society.

The minister has made a very firm commitment to tobacco control. She sees it as one of the strategic priorities of the ministry. As you know, all parties of the House have committed to a vision of health and health goals developed initially by the former Premier's Council on Health Strategy, the first line of which is: "We see an Ontario in which people live longer, in good health, and disease and disability are progressively reduced."

In order to achieve the vision credibly, we must pursue an ambitious agenda of tobacco control. The first goal, of course, is to shift emphasis to health promotion and disease prevention, and the tobacco control strategy is the cornerstone of our efforts in that area.

There's a single purpose for the tobacco strategy, and that is to reduce tobacco use. We have set out some fairly ambitious targets which have also been articulated by the Premier's council. They are by the year 1995 to increase to 100% the proportion of schools, workplaces and public places that are smoke-free and to eliminate tobacco sales to minors. We'll not achieve those objectives without this legislation. We also wish, by the year 2000, to reduce

total tobacco sales by at least 50% and by at least 5% in each year during the 1990s. I think you'll agree that these are ambitious objectives.

We also wish, as Richard has indicated, to reduce tobacco use, that is, the prevalence of tobacco use among adolescents 12 to 19 years of age to 10% by that year, to reduce the proportion of men and women who smoke to 15% and to eliminate the use of tobacco products by pregnant women.

This is a complex problem, we all agree. There are no magic bullets and we need a comprehensive, integrated approach to effect the change towards these targets. We've put in place a number of planning mechanisms, including the creation of an interministerial committee on tobacco control, which is chaired by the chief medical officer of health.

It includes ministries—Finance, Labour, Education, Municipal Affairs, and the list goes on and on—all the ministries that are concerned with various aspects of the tobacco problem. We are planning together to determine how we may reach the objectives and targets of the strategy together as a government strategy.

1450

We have also convened a steering committee of provincial partners in the strategy. I know you'll be hearing from many of those partners during the committee's hearings, including the major voluntary organizations—the Canadian Cancer Society, the Lung Association and the Heart and Stroke Foundation—as well as the resource centres that we've funded under this strategy. This will provide a mechanism for us to develop an integrated plan.

The legislation which is being discussed today is seen by those partners as an essential element of the strategy. As I mentioned, it is our judgement that the objectives will not be achieved without the legislation, particularly that related to the sale of tobacco to minors and the restrictions on smoking in public places.

The minister mentioned that we have introduced a hard-hitting mass media communications strategy, an investment of about \$3 million this year, through the electronic media, including cinema advertisement and television ads directed to children, the use of radio spots, print ads in newspapers directed at children and supplementary material. All of this information will be available to the committee, of course.

We have made a commitment to develop educational resource materials and make these widely available through the school system and other mechanisms. The minister made grants during National Non-Smoking Week to our partners to develop and make these available province-wide. These are programs related to smoking cessation, for example, and increasing community awareness of the tobacco problem.

We've supported the establishment of four resource centres. We're a funding partner in the National Clearinghouse on Tobacco and Health, which is a focal point for information exchange and networking. We've just created a program training consultation centre which will provide support to the local public health system in

the implementation of mandatory health programs and services guidelines related to tobacco use prevention. They will also be supporting voluntaries and implementing their aspects of the strategy and be supporting community health centres in their role in delivering smoking cessation programs and related community development activities.

We fund a group called the Smoking and Health Action Foundation. You'll recognize Mr Garfield Mahood's name, and he will be here. We're supporting him with various public education campaigns and community organization work, and the Council for a Tobacco-Free Ontario, which is the provincial interagency council on smoking and health that organizes National Non-Smoking Week and World No-Tobacco Day activities.

In order to ensure that our program is as effective as it can be, the ministry is providing financial contribution to the University of Toronto to establish an Ontario tobacco research unit. Roberta Ference, the principal investigator, is organizing a provincial network of scientists to assist us with research into what is the most effective intervention in the policy and program area, and she'll be able to speak to many of your questions. It also provides us with a mechanism to monitor and track progress towards the attainment of strategic objectives within the strategy, and there will be reports regularly from the resource centre as to how we do.

At the local level, Richard has already mentioned that public health is very active in tobacco control activities, supporting local interagency council activities. We've funded a demonstration project in Brant. I believe the Brant post-commit group is scheduled to be at your London meeting. They'll be able to tell you about their activities. We also plan to establish two more demonstration sites to implement the comprehensive integrated model to tobacco control at the local level.

The tobacco control strategy is the first comprehensive integrated prevention effort by the Ministry of Health. It is recognized by other provinces to be a model. We're very early in its implementation but we're hopeful that, if it's implemented in its entirety, including legislation, we'll be successful in achieving the targets we set out.

That's an overview of the strategy, and I'd be pleased to answer any questions.

**Mr Jim Wilson:** I don't have any questions, but I was wondering if I could get some information from the ministry in terms of all the various community groups or organizations funds with respect to the tobacco issue. Is there a list available or is it out in some report somewhere that I haven't seen?

**Mr Garcia:** There's actually a list included in your briefing binder, and we'd be happy to provide further information.

**Mr Jim Wilson:** Does that list include the annual grants to those organizations?

**Mr Garcia:** I don't believe it does. We could provide a list.

**Mr Jim Wilson:** Mr Chairman, for the record, I don't ask for that in any malicious way. I've just been asked



that by constituents who get letters from these groups from time to time, from the pharmacists, saying, "How much money does the government give to these groups?" I think it's a fair question: How much money does the government give out in grants to these groups, and what are the groups?

**The Chair:** That information could be made available to the clerk and then subsequently to the members.

**Mr Garcia:** Sure. A very quick answer to that: We spend about \$1 million on resource centres. Their recent grants for the development of education resource materials was slightly more than \$600,000.

**Mr Jim Wilson:** That's just resource centres?

**Mr Garcia:** That's correct.

**Mr Jim Wilson:** That's not anti-smoking advocacy groups?

**Mr Garcia:** The Smoking and Health Action Foundation, for example, is one of the resource centres of the strategy.

**Mr Jim Wilson:** My question pertained to, in addition to the centres, the community groups that might receive grants from the Ministry of Health.

**Mr Garcia:** We could provide a list. We do this regularly.

**The Chair:** We'll have that circulated to the committee members. Any other specific questions for Mr Garcia? Otherwise, we'll move on and continue with the briefing.

**Mr Jim Wilson:** I just want to compliment this branch of the ministry. I was in the theatre a couple of weeks before Christmas when your Swimmers cinema ad did get a very large round of applause from the audience, and clearly spontaneous. It's an excellent ad campaign and I'd be interested, when you do the analysis of that, if that could be conveyed to the committee. I suspect some time will elapse before we see whether that's effective or not. We don't very often see the national anthem played, and when it's played people don't stand any more, but they sure responded to that particular ad.

**Mr O'Connor:** Moving along, as the committee members know, maybe not those viewing, we've had some discussion over the strategy up to this point, and of course last March there were presentations that took place. We heard from 240 people and 34 oral presentations. The member for Perth, of course, was there on the receiving end for quite a bit of it, as I was myself.

Brenda Mitchell was on the receiving end for a lot of that as well and helped us to develop the legislation. Now I'd ask her, as the manager of the tobacco strategy unit, if she would go through the legislation and just highlight the clauses in it, and then perhaps we can have some questions on that as well.

**Ms Brenda Mitchell:** You have a copy of Bill 119 in section 1 of the binder. I'll be following through this bill. For each section what I will do is briefly highlight what the section of the act does and give a brief rationale as to why it's included in the act.

I will start with section 2, which has to do with the application of the act. This would apply "to tobacco in any processed or unprocessed form that may be smoked,

inhaled or chewed." We're trying to be comprehensive in terms of reaching the types of use of tobacco.

There is an important note that it "does not apply to products intended for nicotine replacement therapy." This is because the source of nicotine for aids for cessation, such as the nicotine in Nicorette gum or in the patch, comes from the tobacco leaf. That's why it does not apply to those aids.

Section 3 of the act prohibits the selling or giving of tobacco to a person who is less than 19 years old. The current law in Ontario is the age of 18, so this is an increase of one year. This age will effectively remove tobacco from high school students and will also treat it consistently with alcohol.

In order to aid with the enforcement of this age, there is a requirement in subsection 3(3) that unless the retail vendor knows that the person is of age, if the vendor suspects they may not be, it's their responsibility to ask for photo identification. The forms of identification would be specified in regulation. There would be an onus on the tobacco retailer to ensure that the person is of age, and that will help the retailer comply with the law.

1500

In section 4 there is a prohibition on sale of tobacco in designated places, specifically on the sale in health facilities, and this does include the sale of tobacco in pharmacies.

Section 5 is on packaging requirements. There would be a requirement to meet regulations and that all tobacco sold must meet the regulations. We have identified in the notes provided in the committee book on this section that the regulations intended in this area have to do with controlling, at this point in time, package size, but of course we are interested in hearing comments on what other regulations there may be.

In addition, there would be a requirement that on the package there be health warnings and possibly other health information. It's being proposed at this time that the regulations on health warnings would bring the provincial law in line with the new federal law.

Under the Tobacco Products Control Act, which is federal legislation, health warnings are required on cigarette packages. There is a new regulation which will come into effect in September 1994, and Ontario would be looking at having a regulation that would duplicate the requirements. The federal Tobacco Products Control Act has been challenged by the tobacco industry and an appeal will be heard by the Supreme Court of Canada, it's anticipated, some time this year.

Section 6 has to do with signs required at the point of sale of tobacco. The content of the sign would include two things. One is pointing out the age restrictions on selling and giving tobacco, and the second would be a health warning.

Larry O'Connor mentioned that we had presentations made to us last March after we released a discussion paper on proposed legislation. Many of the groups who spoke to us emphasized the importance of embedding the age restriction in the health warning so it's clear why the age restriction exists.



Under the federal Tobacco Sales to Young Persons Act, there will be a requirement for signs at the point of sale of tobacco. They have put out their regulations. There were gazetted January 22, so we now know what they are. The federal regulations state that where the provinces are more restrictive in terms of having a higher age and also require signs at the point of sale, the Ontario sign would stand. That would be the signage required. They would waive the requirement for the federal sign itself. However, the federal regulation does specify where the signs would have to be posted. It's anticipated that that law will come into effect in July 1994.

Section 7 deals with vending machines and would prohibit the sale of tobacco from vending machines. There's also a requirement under the Tobacco Sales to Young Persons Act which would restrict vending machines to premises that are bars or taverns. In addition, they have identified that where the premise is one that can be accessed by a person under the age of 18, there are additional requirements. Again, according to the regulations that were gazetted on January 22, the vending machine would have to be under the supervision of and monitored by whoever was in charge of the establishment and would have to be a minimum of five metres from any entrance to the premise.

Section 8 of the act deals with reports from wholesalers and distributors. This would allow Ontario to collect information about who sells tobacco and also what tobacco is sold and where it is sold. This information is important to allow Ontario to enforce this act and its regulations and also for us to monitor how well we are doing with the implementation of the tobacco strategy, where the effectiveness is and where we need to take other kinds of action.

Section 9 of the act has to do with prohibitions on smoking in certain public places. There are eight specific types of premises identified, as well as saying under paragraph 9 "a prescribed place," which would allow further places to be specified in regulation.

You will see that the types of premises included here really fit into three categories. One is premises that are specifically for children, and this has to do with protecting children from exposure to tobacco smoke, a point Norm Sterling already spoke to this afternoon. The second has to do with restricting smoking in health facilities, and the third has to do with allowing people to go through their routine activities of life in a smoke-free environment.

Section 10 deals with no-smoking signs. It's important that where smoking is prohibited people are aware of that prohibition, and voluntary compliance will follow if they are aware.

Section 11 speaks to conflict with other legislation. This is placed in the act at this point to draw to people's attention the ability of municipalities to have more restrictive bylaws on smoking in public places. Certainly many municipalities already do have more restrictive bylaws; because we live and work in Toronto, I think we're very familiar with them. Bill 119 sets minimum standards for prohibitions on smoking in public places across the province, but certainly municipalities may go

further and we wanted to make it clear that the most restrictive law would apply.

Section 12 of the act deals with traditional use of tobacco by aboriginal persons. We acknowledge that the traditional use of tobacco in the aboriginal culture and spiritual practices is different from other use of tobacco. Therefore, we are basically giving permission that tobacco being used in this way does not fall under some of the prohibitions in the act.

Section 13 deals with enforcement of the legislation, particularly to do with the rights of inspectors.

Sections 14, 15, 16 and 17 of the act deal with various levels of penalties that would come into play if someone is convicted. The offences labelled and specified here deal with fines, in addition to which there's an automatic prohibition that can come into play for tobacco retailers who have received two convictions; the terms of the automatic prohibition are outlined in section 15.

Sections 16 and 17 follow from that: Where a premise is under a prohibition of selling tobacco, it may not have tobacco on the premises, and there's right of seizure for that. Also, there must be a sign posted on the premises making it clear that the prohibition is in place. This will alert the community to the fact that tobacco is no longer available because they've been convicted for violations of the law.

That basically covers the content of the act.

**1510**

**Mrs Haslam:** I wanted to ask a question around what Mr Sterling said earlier about the college being given more power to self-regulate the selling of tobacco. I wondered if any additional power at all was given to the college of physicians around that.

Also, Dr Schabas was talking about the long-term effects of the legislation. I wondered if any thought had been given to a tobacco control board similar to an LCBO, especially given that you said you shouldn't bring everything in at once. Would one of you like to comment on whether that is a possibility for the long term? Is that one of the visions you have in steps towards taking care of this problem? I understand that you can't jump in. I wondered if it was there as a dream for the long term, a hope or vision written down someplace.

**Ms Mitchell:** In terms of the pharmacy section, the way we dealt with this in legislation was something worked out with the college itself. We met with them and agreed that this was the best way to deal with it. Frank might like to speak to legal options of how to deal with that.

**Mr Frank Williams:** Generally speaking, colleges deal with issues of competency and with how professionals engage in the practise of their particular profession, so the college would be more interested in competency issues, I would think, than what particular pharmacists can and cannot sell. I suppose they could add an item as part of professional misconduct, selling tobacco products, but the college never gave us any direction that it wanted to go in that particular direction.

**Ms Mitchell:** In terms of the tobacco control board, we certainly looked at a number of options for dealing

with the sale of tobacco. Is it possible for you to clarify what you think a tobacco control board would—

**Mrs Haslam:** I'm asking because Dr Schabas said we talked about bringing it all in at once and we talked about making decisions in an incremental way, and that this was a good time to bring in this type of legislation in an incremental way. I'm asking whether long-term you are still in favour of or have thought about bringing in a tobacco control board similar to an LCBO when you talk about the selling of this particular product. Maybe Dr Schabas could answer that, as I didn't get a chance to ask that question when he was here a minute ago. But you're dealing with regulations in this legislation and that's why I'm asking now.

**Dr Schabas:** I'll answer that question in a slightly circumspet manner, but I will try to answer it. Clearly, it's not included in the current legislation. It's something that's been discussed various times in the past, and it's the judgement of the minister of the government at the moment that it's not a measure that's acceptable or that we're ready for at this point in time.

But we also know in Ontario that the use of a liquor control board has been one of the tools we've used with some success in reducing levels of alcohol consumption and controlling consumption among underage young people and in certain situations. I would like to think it's the kind of issue we could revisit, because social attitudes about smoking have changed dramatically in the last decade. We now have measures of restriction of smoking in public places that would have been unimaginable 10 years ago. I very much suspect that five or 10 years from now, what is currently unimaginable or unacceptable will be very imaginable and I hope very acceptable.

**Mrs Haslam:** Are you of the opinion that this is not the time to bring in that measure? I suppose you would like to see it brought in. I'm just trying to look at the social norms now and whether you, in your position in public health, feel this isn't the time, or would you like to see us bring it in?

**Dr Schabas:** I'm not sure I'm the right one to make that judgement. As a public health officer, I will advocate for measures that will promote public health and, in this case, will reduce access to and consumption of tobacco. But it's really an issue for the Legislature and for the members of this committee to decide what is reasonable and practical at this point in time. That refers back to Mr Eddy's question earlier about what measures we are willing to accept, because we probably all share the long-term goal that we'd like to eliminate tobacco use.

**Mr Garcia:** One point I would make is that in deciding whether one would go in the future with a tobacco control board or an alternative licensing system, one needs to look at the policy objective that would be served by doing that. It's our interest to be able to prevent retailers who sell tobacco to minors from doing so in the future. We believe the sanctions that are included in the current legislation will be effective in doing that. I think it would be prudent to determine whether we're effective in achieving the compliance objectives we want. Maybe in the future there are other options that need to be considered; I wouldn't rule that

out for the future. But at this point, we think we have an enforcement mechanism that will be effective in achieving the objective.

**Mr Paul Wessenger (Simcoe Centre):** My questions are probably going to be a little more technical. First of all, section 3 of the act, I assume there is an equivalent section in the Minors' Protection Act. Was the restriction there on selling or giving, or selling only, in the previous act?

**Ms Mitchell:** It's broader than just selling. The Minors' Protection Act states, "No person shall either directly or indirectly sell or give or furnish to a child under 18 years of age cigarettes, cigars or tobacco in any form."

**Mr Wessenger:** Why did we change the language? Do we feel this is plainer? Do we feel we're losing any legal rights by not using the language that was in the previous act?

**Mr Williams:** It's drafted by legislative counsel, so we deferred to their choice of language at this point. We're certainly open to suggestions. If the committee feels perhaps this doesn't go far enough, we're willing to consider changing it if necessary.

**Mr Wessenger:** The intention is not to in any way change the standard from the previous act to this act. Is that the intent?

**Ms Mitchell:** That's right. The intention is that it should not be narrowed in any way.

**Mr Wessenger:** The second question relates to section 5, which gives the power to make regulations with respect to packaging. I assume this would give the government the power to implement plain-packaging requirements if that were felt to be appropriate.

**Ms Mitchell:** If the government chose to follow that option, this gives the government broad scope to do what it feels necessary with packaging.

**Mr Wessenger:** Section 7 says, "No person shall permit a vending machine for selling or dispensing tobacco to be in a place that the person owns or occupies." Is the intention there to put a liability on both the owner of the premises and the occupant?

**Ms Mitchell:** Yes, it is.

**Mr Wessenger:** With respect to section 8, what is the purpose of requiring the wholesaler to make reports?

**Ms Mitchell:** When we identified that we wanted reports, we were looking for a system that would be fairly efficient and would not put a burden on the small businessman. We didn't want to put a burden on each tobacco retailer.

**Mr Wessenger:** Then you did consider requiring a report by each person at the retail level with respect to tobacco.

**Ms Mitchell:** It was something we looked at, yes.

**Mr Wessenger:** On the same basis as the packaging regulations, might it make sense to at least give under the legislation the power to require discretion reports from a retailer? It's just a suggestion.

**Ms Mitchell:** I suppose it could be considered, certainly.



**Mr Wessenger:** With respect to section 9, I have some concern. Is there a definition anywhere of "a retail establishment"?

**Mr Williams:** It would have whatever normal meaning it would have in normal parlance. Certainly case law would support what would normally be the interpretation of "a retail establishment," what you and I and everybody else considers a retail establishment. It doesn't have any special hidden meaning beyond its normal, everyday meaning.

**Mr Wessenger:** That was certainly my impression, but I look at that and then at some of the subsidiary definitions under section 9. We have, for instance, "a hairdressing establishment or barbershop." I would submit that in ordinary understanding that would fall under the category of a retail establishment. "A self-serve laundry" might also fall under that category. I'm suggesting that by having the two specifics set out as well as "retail establishment," we're leading to the difficulty of having a retail establishment being more narrowly construed.

**Mr Williams:** I think the intention was to at least zero in on those particular retail establishments about which perhaps there was some doubt as to whether they would fall under the definition, but it's also to make it abundantly clear that those were establishments in which we wanted to ensure that there was no smoking or selling taking place.

1520

**Mr Wessenger:** Another question relating to where people may smoke: We seem to be very concerned about prohibiting the sale of tobacco in health establishments, and there seems to be an underlying premise that where numbers of consumers are in a common situation together, smoking of tobacco would be prohibited to prevent the ill effects of second hand smoke. Just a suggestion, but did you consider designating doctors' offices, for instance, as places where you shouldn't allow smoking? Certainly there are large numbers of people sitting in a doctor's office, and I'm just wondering if that's been considered.

**Ms Mitchell:** We've looked at quite a number of premises and certainly we've been advocated on that. I expect we will hear quite a bit about that in the next few weeks.

**The Chair:** Ms Haslam, you said you wanted a clarification on one point.

**Mrs Haslam:** It was something Brenda said on section 6. You were talking about the federal signs coming into a situation where the provincial signs are also in legislation, that the federal signage would be waived for Ontario signage. But then you said the federal says where it's to be hung. I wanted a clarification of who has jurisdiction. You're saying a provincial sign would have jurisdiction over a federal sign, but a federal sign would have jurisdiction over where it was hung?

**Ms Mitchell:** Sorry; let me clarify. There are two components to the federal regulation. One component specifies typeface, colour, borders, that type of thing, and the actual wording. If theirs says—I can't remember exactly what it is—that selling or giving to a person

under the age of 18 is illegal, in the case of Ontario, because it's age 19 and we would also have health information, the content of the sign could be specified by Ontario.

The second part of their regulation deals with where the signs are posted. Essentially, they require that wherever tobacco is sold, the sign has to be located by the tobacco. If in a store there were many places where tobacco was sold, the signage would be required at each point. Ontario would specify what the content of the sign would be, but the posting requirement would be with the federal law.

**Mrs Haslam:** In other words, Ontario didn't put in any regulation about where it should be, relying only on the federal legislation for that particular issue.

**Ms Mitchell:** Ontario could specify where the sign is posted; in fact, depending on how we interpret the federal regulation, we may wish to clarify. It's simply that in the federal regulation they stated in terms of the content that if the province was more restrictive it would apply, but they made no statement about exempting in terms of where it was posted. Frank may wish to speak to that.

**Mr Williams:** There would be nothing to prevent the province from requiring signs in addition to those places the federal government would prescribe, for example, but there's been quite a bit of consultation back and forth between us and the federal government and the other provinces as well on both the content of the signs and where they're to be located.

**Mr McGuinty:** I have a few questions, but I'm not sure specifically to whom they should be addressed. I'll just put them out.

I think it would be unreasonable not to at least anticipate a constitutional challenge with respect to the ban on tobacco sales in pharmacies alone. Has the government obtained a legal opinion in that regard from anybody?

**Mr Williams:** I've had some contact with my counterparts at the constitutional branch of the Attorney General, and I'd make two comments. First, we don't look at pharmacists as retailers but as being another category of health professionals, so from that perspective we treat them the same as other health professionals. And certainly the courts have not looked at economic disability as being something that's a charter issue. Our view, from both our own legal branch and what I've heard from the Attorney General, is that there is no constitutional issue involved here.

**Mr McGuinty:** If one was launched, how would that affect the legislation in the interim? Would it apply, or would it be up in the air?

**Mr Williams:** My view is that a law is good until it's struck down by the courts, so I would assume the law would be valid until the courts struck it down.

**Mr McGuinty:** Dr Schabas raised the issue of a mixed message. I think a good argument can be made to that effect, but has that been grounded on any studies or research? I may be repeating the question raised by my colleague. Do kids perceive it as a mixed message? I'll tell you why I raise the question. I have four young kids, from seven to 12, and I know if I were to ask them what



happens at the pharmacy, they'd say, "Well, that's the place where we get diapers and we get a hell of a good price on chips, and we get shampoo and soaps and cosmetics, and yeah, when we're sick Mummy will get a prescription there." It's seen as a combined retail and health care establishment, so I don't know if they'd see it as a mixed message as such.

**Dr Schabas:** Let me answer your question in several ways. First of all, there is research evidence that the mixing of the message is important. Things like the smoking behaviour of teachers, for example, have an important effect on the effectiveness of classroom teaching around tobacco, and the actual smoking behaviour of parents has an important effect on the smoking behaviour of children. There is ample reason, both intuitively and from a research standpoint, to recognize that consistency of message is important.

I don't know of any research that specifically addresses this issue of perception of pharmacies. I certainly believe the banning of tobacco sales in pharmacies will reduce tobacco use by young people, both through reducing the number of outlets and through sending a consistent social message, but I can't point to one piece of research that categorically proves that.

**Mr Garcia:** Perhaps I can add to that. We believe a ban on tobacco sales in pharmacies has a place in the context of a comprehensive strategy, and we believe it will have an impact on consumption. The college of course has made the argument on different grounds: that pharmacists shouldn't, in professional practice, be engaging in the distribution of a product that's hazardous and addictive and responsible for so many deaths. We're not dealing with confectionery here; it's a drug that kills people.

While the evidence is somewhat thin in terms of tobacco consumption per se and what the impacts may be, or even in terms of the reasons for the declines in consumption to date, there is reason to believe that the prohibition of tobacco sales from pharmacies will have some effect. It's part of the comprehensive approach.

The Addiction Research Foundation, which we consulted on this matter and which is aware of the impact of fewer outlets for alcoholic beverages, tells us there's reason to believe that restricting the number of outlets that sell tobacco products will have an impact on consumption. It's difficult to know what proportion of the total market is distributed through pharmacies. According to the committee of independent pharmacists it may be as low as 6%, or it may be as high as 25% by other groups, but it's still a significant amount of the market. We do not know what the impact will be. Maybe there will be a displacement to corner stores or maybe it will go into the underground economy; it's difficult to know exactly. But we believe it's part of a comprehensive strategy. This does not suggest that other approaches are not needed to deal with these other problems of smuggling and so forth.

**Mr McGuinty:** Section 9 talks about the prohibition of smoking in certain places and it makes reference, in paragraph 2, to "post-secondary educational institutions." I assume that means our colleges and universities. Does that mean there's a campus-wide ban on smoking?

**Ms Mitchell:** We're reviewing that ourselves right now to determine what the scope of the ban would be. In the point above, there's a prohibition on smoking in health facilities, and we're allowing an exemption. We're considering doing a similar kind of thing here, the idea behind that being that people should be able to go to colleges and universities and pursue their education and do that in a smoke-free environment. That's the intent.

**Mr McGuinty:** I'll tell you why I raise that. I'm the Colleges and Universities critic and it's been raised with me by students. The example put to me was, "If I'm a student and I have a room in a residence on campus and I'm in that room alone, am I allowed to smoke?" That's the question.

**Ms Mitchell:** I think it's a legitimate question to ask. In the point above, with health facilities, the allowance for an exemption was put in there because some health facilities are in fact people's residences. We could certainly look at an exemption for a residence on university campus.

1530

**Mr McGuinty:** One final question: The bill seems to tie in nicely with what the feds are about to do, but you seem to go ahead of them with respect to an outright ban on vending machine sales. Why didn't you think the regulations the feds proposed, insisting that they be supervised, that they be located at least five metres away from the doorway—I looked at the impact of similar legislation in some of the American states. The results there seem to be pretty good in terms of ensuring that young people didn't get access to cigarettes through vending machines. I'm just wondering why we didn't try that first.

**Ms Mitchell:** As a general comment about the difference between federal and provincial legislation, I think it's quite fair to say that the federal government and provinces in addition to Ontario are moving in the same direction; however, the provinces tend to provide a little more leadership than the federal government on this issue. For example, Nova Scotia has already banned vending machines. Similarly, if you look at age, the federal law is going to 18. Four provinces have now gone to 19 and Ontario would be the fifth. You could look at it as being that the federal government sets some minimum standards for this country and the provinces have the opportunity to go beyond that.

If you have some information that says that other things besides a ban on vending machines are very effective, we would be interested in seeing it. We've gathered quite a bit of evidence that shows there is no effective mechanism to ensure that minors do not have access to tobacco from vending machines, other than a ban.

**Mr Williams:** Another thing worth noting is that the federal legislation provides an exception for licensed premises. In most provinces other than Ontario, minors are not allowed into licensed premises, as you're probably aware, but in 1988 the laws in Ontario changed such that minors are now allowed into certain licensed premises: restaurants and the like. The intention of the federal legislation to prevent access of minors to vending

machines would work in most provinces, but it wouldn't work in Ontario. This is another reason we've expanded the legislation the way you see it.

**Mr McGuinty:** The minister earlier mentioned that perhaps the people running these establishments could carry loose cigarettes: packages or cartons, whatever. But as you realize, cigarettes today have become a hot commodity, and a lot of people have now stopped carrying cigarettes because of the problems associated with theft and break-ins and that kind of thing. They are not prepared, at least in some cases, to carry cigarettes behind the bar.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I'd like to go back to section 9. There are two or three things I'd like some comments on. Subsection 2 says "a school." In many of the rural communities of Ontario, the school is the community centre. It also has wedding receptions, dances; it is the only place. Does that mean that a school is a school is a school all hours of the day, no matter what the function?

**Ms Mitchell:** That's correct.

**Mrs O'Neill:** And that will then have to become board policy across the province when this act is proclaimed, is that correct?

**Ms Mitchell:** The provincial law will be that smoking will be prohibited in schools, both in the buildings and on the grounds, at all times.

**Mrs O'Neill:** That's going to be quite interesting in some of the rural communities.

"A shelter or station used as part of a public transit system": In my community, many of the shelters are outside and very open; in fact, there are a lot of complaints, especially with the temperatures we've been having. We have a very, very small enclosure, and two sides of the building are not enclosed. And some of the transit shelters are not enclosed at all; they're strictly designated areas of the road. What does that mean?

**Ms Mitchell:** What we were looking to here as the model was the city of Toronto bylaw, which I think those of us who ride the TTC regularly are familiar with. We could talk to them about how they're applying it, but if something is clearly part of the TTC system or is in the glass transit shelter, which is a three-walled structure in Toronto, that is a transit shelter and that's how it's applied. If it's simply a TTC sign on a post in the road, then it's outside, and the law wouldn't apply.

**Mrs O'Neill:** I think those who are viewing this today in some other cities would have some difficulty with what you've just said, that you took the TTC model, because there are a lot of other forms of transit. We have to be sure that the law covers more than the city of Toronto. I'm sure you're going to have transit systems in the province asking questions about that, because the shelters are different and the transit systems are different in the way designated areas are included.

What does paragraph 9 mean: "a prescribed place"? In regulations, are you going to be stating other places than what is listed here? Is that what that means?

**Ms Mitchell:** "A prescribed place" would allow the government, through regulation, to add places at a future

time. However, at this time we are not intending to have a regulation with additional premises at the time of proclamation.

**Mrs O'Neill:** So even though we're going into a set of hearings for four weeks, you're not going to add any places at this time.

**Ms Mitchell:** That's the intent, that we would not add places at this particular time. What we were looking at was that over a number of years, certainly if you look at the past 10 years, we've seen social attitudes change enormously in terms of where it's acceptable to smoke or not smoke. It's important that we have the flexibility in this act that we can change the regulation in the future to keep pace with social attitudes.

**Mrs O'Neill:** Paragraph 4 says, "those parts of the premises of financial institutions that are open to the public." Does that change the way the law is applied in those particular workplaces? That's what they are. Does that mean all the public areas come out of the designation of "workplace"?

**Ms Mitchell:** A public place is not part of a workplace. The Smoking in the Workplace Act would apply to the remainder of the workplace, but financial institutions are also workplaces that are affected by federal legislation. Because what we're trying to do is allow people to go through their daily activities in a smoke-free environment and because this section deals with smoking in public places, we're talking about part of a facility that's a public place, and smoking would be prohibited. Under the Smoking in the Workplace Act, they can differentiate between a public place and the workplace. The workplace would be the area the public doesn't access.

**Mr Arnott:** My first question deals with section 3, which indicates you can't smoke until you're 19. You indicated the rationale behind that is to take it out of the high schools, correct?

**Ms Mitchell:** That was one of the reasons.

**Mr Arnott:** I've been approached by a few constituents on this issue, and you've heard this too, I'm sure: "You're old enough to vote at 18, you're old enough to join the army at 18 and, if there's a war, to potentially die for your country, yet you're not allowed to smoke until you're 19." I wonder about that. I also wonder about whether it has the effect you're hoping to achieve. A lot of high school kids are still going to high school for five years: If you assume they go in at age 14, which most of them do, they're still in high school at 19, if they stay in the OAC program for five years. So you're not going to have the effect of taking it out of the high schools.

1540

**Ms Mitchell:** There are people who will attend high school and who teach in high schools who certainly have the right to choose to smoke, and they may carry their personal cigarettes with them. We were trying to create an atmosphere in the schools where smoking is not acceptable. Basically, most high school students are indeed under the age of 19. My impression was that people are leaving high school earlier these days than they had been when I went to high school.



The other part of it is that in order to make the sale to minors really enforceable, we have to have photo ID that can be used and is readily available to anybody. If you are the retailer in a store and the onus is on you and you're going to say to this person, "Could I please see some identification that shows you're of age," this person may well have an age of majority card because that's the readily accessible piece of ID to show age. We do have to have something that's operational.

**Mr Arnott:** In section 9, you've got nine examples of places where smoking will now be prohibited as a result of provincial legislation. I'm trying to get an understanding of the rationale behind those that have been picked and those that have been excluded. You talk about public places, but I don't see community halls here, for example, community arenas, churches. The minister at our church used to smoke his pipe all the time, and that's still not on the list. Restaurants: You're excluding some and including others. I'm not being critical. I'm just trying to understand the rationale for what has been included versus what has been excluded, places that appear to be subject still to municipal regulation.

**Ms Mitchell:** One of the ways you could look at it is that there are some areas that are fairly clear-cut in terms of where you don't want the smoking to occur. I presume the minister did not smoke in the sanctuary but probably in the private offices.

**Mr Arnott:** That's correct.

**Ms Mitchell:** In places like churches and community halls and arenas and what not, people do have very mixed feelings about where the smoking should be permitted or not permitted, and it would get into that kind of definition. But certainly if the feeling were that there are other parts of the community, such as recreational centres, where smoking was not appropriate because it is a community centre, the committee could consider that.

**Mr O'Connor:** One thing I'd like to point out is that in many jurisdictions the legislation goes far beyond what we've got here as a list. Many municipalities are far more inclusive about areas that are prohibited, and we're going to hear that, no doubt, as we go through the public hearings. Section 11 addresses that, so that the municipalities that do have tougher bylaws and legislation will still have the impact they've legislated locally.

**Mr Arnott:** I agree, but as Mrs O'Neill pointed out earlier, if you have an example where the school is the only community hall and is used that way in a small municipality, and in an adjacent town there is a small arena and smoking is allowed based on the municipal bylaws, there's certainly an inequity there, a difference.

**Mr Garcia:** To perhaps clarify and add to the points Brenda made in response to Mrs O'Neill's question, the ministry is going to be listening very closely to the deliberations of the committee and taking political direction. We realize this is the process. I know you will be hearing quite a lot from health groups that the list is simply too short and they will be pressing for an extended list of public places to be included. What Brenda is trying to reflect to you at this time is that we do not have any plans to go beyond this at this point, but of course we're taking political direction.

**Mr Jim Wilson:** I'd like clarification on a couple of points. With section 4 you're banning the sale of tobacco in designated places—hospitals, psychiatric facilities, nursing homes, homes for special care, charitable institutions, homes for the aged and rest homes, pharmacies of course, and retail establishments under prescribed circumstances—and then in paragraph 1 of section 9 there is an exception for designated areas. Will residents of a psychiatric facility still be able to have a designated smoking area? Is that the intent?

**Ms Mitchell:** Under section 9, there could be an exemption for a designated smoking area in psychiatric facilities. That would be specified in regulation, and in the process of writing the regulation we would be in consultation with representatives of that community.

**Mr Jim Wilson:** The committee's been sent a rather extensive petition from Penetanguishene mental health institute essentially opposing the act as written, because its interpretation is that its patients will not be allowed to smoke. The residents there are quite upset about that. I think they make a very good point in their petition, which says they're under enough stress and a lot of them do smoke, and now to suddenly be thrown into an institution where you can't smoke might be more than some of them can take. You can't just tell us you're going to do that in the regulations. You must have made up your minds by now.

**Ms Mitchell:** The ministry is sympathetic to the issue of psychiatric patients and smoking. We know that smoking rates in psychiatric facilities are extremely high. We're trying to balance also that if you are a psychiatric patient, you should have the right to be a psychiatric patient in a smoke-free facility. In addition, you have to consider the amount of smoke you're exposed to if you're a worker in a psychiatric facility. We're certainly open to discussions with them in defining what the exemption would look like.

**Mr Jim Wilson:** Again under paragraph 4(2)9 that deals with retail establishments, I just want to clarify this: If you've got a large Zellers store that has a pharmaceutical counter at the back, can the Zellers store sell tobacco products at the front, as it currently does?

**Ms Mitchell:** Not if it's one premises. The Ontario College of Pharmacists and other organizations have made it very clear to us that they want a level playing field, that all pharmacies be treated the same. Therefore, whether the premise is a pharmacy or simply includes a pharmacy, the ban would apply.

**Mr Jim Wilson:** I wonder if the wording here catches the pharmacy in the mall with the smoke shop next door to it.

**Ms Mitchell:** If the smoke shop is next door and it clearly has its own entrance off the main mall and you can't go back and forth between the pharmacy and the smoke shop, then certainly the smoke shop can exist in the mall.

**Mr Jim Wilson:** I'm wondering about this laundry room business. If you've ever been to a laundry in a small town, it's very much a social gathering. In fact, I campaign in them because you meet a lot of people.



Whom did you consult about this one? The medical officer of health has testified that a lot of poor people smoke, and they're probably using laundromats because they can't afford washers and dryers. In your fine chart, it could be \$5,000 for being caught two or more times smoking in a laundromat. That's a bit ridiculous. Next you're going to say that because the Criminal Code calls cars a public place in terms of purposes of prostitution, you can't smoke in your car.

My colleague, in error, said you had a list of nine prohibited places. You have an infinite list of places here, because the ninth point is "a prescribed place," and given that you're not about to share with us all those other prescribed places, basically this is a slippery slope, as I see it. You're hitting laundromats, retail establishments. I can see it in schools and nurseries. Mrs O'Neill raised a very good point about public transit shelters. In my area, sometimes a tree is a public transit shelter. There's very often just a centre pole with a T over it for a little bit of shelter. We're not all living in Metro, thank God. A hairdressing establishment or a barbershop? Have you ever been to a barbershop?

**Ms Mitchell:** Yes, I have.

**Mr Jim Wilson:** I think you've gone a bit far in your list. I'm a little irate about excluding pharmacies. I know some municipalities have, but the reason we have municipalities is to reflect local values. They will decide whether barbershops in their particular area, after consultation with the local barbers, want to ban smoking, or whether the people in the laundromats, of which every town has one, want smoking banned. You're putting a blanket law in, and I'd like to know who the heck you consulted with respect to those places.

1550

**Mr O'Connor:** A wonderful question, Mr Wilson. I don't know whether during National Non-Smoking Week you had an opportunity to talk to some of the young people, who were of course trying to keep from becoming addicted to this substance. When I asked the kids—I always do—where they get their cigarettes, they told me the usual places and then some others. Some are that they go into the laundromats and go through the ashtrays and grab great big butts. It sounds pretty gross, and it is pretty gross. These kids are going in there.

The key here is that we're trying to name public places. I don't know whether it was done intentionally, but we've identified a source children are getting cigarettes from after the fact. They've been half-used. It's pretty disgusting, but it's a fact. Restaurant ashtrays are another, and I'll be glad to hear what the restaurant association might have to say. This is what I heard, and I spoke to 10 classes between grade 5 and grade 8 last week or the week before, during National Non-Smoking Week.

The list names some spots, and no doubt as we go through the committee hearings we're going to hear from people who want to see that list extended beyond what we have. I think it's fairly inclusive right now. For a number of people, activities of their daily lives includes going to the laundromat; that's part of their weekly ritual so that they've got clean clothes, so it's pretty evident

why it's there. We'll probably hear evidence that maybe it shouldn't be included, but I think they've included something that will affect the young people we're actually trying to address here.

**Mr Jim Wilson:** Are you contemplating allowing designated smoking areas in laundromats? It's damn cold outside, and if you go to the laundromat behind the Alliston IGA, you have to sit there for two or three hours while your laundry's being done. You might want a cigarette, and it was minus 18 degrees yesterday, a little bit cold. Would they be allowed if the owner were to designate an area under this act?

**Ms Mitchell:** There would be no allowance for a designated smoking area in a self-serve laundry. I can speak as somebody who does do laundry at a self-serve laundromat once or twice a week—sorry, once or twice a month—therefore I think it's reasonable for me to comment that I think I should be able to do my laundry in a smoke-free environment. I'd also like my clothes to come home smoke-free. Also, many of the mothers and fathers who do laundry in a laundromat take their kids along. There are a lot of children playing in there and I think they have the right to accompany their parents and be in a smoke-free environment.

**Mr Jim Wilson:** They clearly found the right person to write this act for them, but in the small town where I live a lot of people still smoke, and they smoke in laundromats. They think it's a right to smoke in laundromats. They'd have a different opinion on that.

I have another technical question. Subsection 13(14) talks about obstruction, and it's talking prior to that about the powers of inspectors. I was wondering about that wording, that a person cannot "refuse to answers questions on matters relevant to the inspection." I'll ask Frank. You probably knew the question was coming because it was raised in second reading debate by Mr McGuinty and myself.

**Mr Williams:** It's fairly standard.

**Mr Jim Wilson:** Is it? It seems self-incriminating.

**Mr Williams:** It's a standard provision. We consulted with the Attorney General on this. The Liquor Licence Act has similar provisions. In fact, this whole section reflects relatively recent developments on inspection, warrants, rights to enter premises that have been developed over the last few years with the Attorney General. It is consistent.

**Mr Jim Wilson:** Above that it talks about the right to counsel prior, I assume, to answering questions from the inspector. Is there any onus on the inspector to inform the person being questioned of his rights?

**Mr Williams:** To the best of my knowledge, you provide your identification and you have to comply with what the inspector requests.

**Mr Jim Wilson:** It says a person "is entitled to have counsel or another representative present during the questioning." Should there not be an onus that people be informed of that right?

**Mr Williams:** They're not being arrested and they're not being charged, so it's not exactly the same.

**Mr Jim Wilson:** It could lead to an arrest or charge, though.

**Mr Williams:** But there are other statutes that have similar provisions. The right to have counsel isn't necessarily provided under those statutes either, and I submit to you there's no difference.

**Mr Jim Wilson:** I'm not asking about the right to have counsel, but the right to be informed of your right to have counsel present. Did anyone ever think that maybe the other statutes aren't perfect either?

**The Chair:** On that note, the final question, Mr White.

**Mr Drummond White (Durham Centre):** Actually, a couple of questions, but they are brief and they are related to the sections in front of us, section 9 to start with. In many areas, in my own constituency as well, schools have designated smoking areas outside of the school building itself but certainly well within the school grounds. I'm concerned that many children—children—are smoking and that that activity is effectively being condoned by the school administration. These are people 13 and 14 years of age in high schools. Would paragraph 2 apply to an area on the school premises as well as within a building?

**Ms Mitchell:** The definition we're using is the definition for a school under the Education Act. That includes the building and the grounds, and therefore under this act smoking would not be permitted on the school property either. That would be a change.

**Mr White:** Anywhere on the school property it would not be permitted.

**Ms Mitchell:** Correct.

**Mr White:** Thank you. The second question, equally brief, is on subsection 15(4), where we're talking about automatic prohibition: "It is a defence to a charge under subsection (3) that the defendant had not received the notice at the time the offence was committed." Under other pieces of legislation, the issue has come up of: "When was I told I had broken the law, or when was I told about the fine? Was I properly served?" etc. I'm a little concerned about that because it might serve to lengthen and make arduous the process of enforcing the law. I'm wondering if that could have any correction on that concern.

**Mr Williams:** Certainly the way the section's worded now it implies that if you can show that you did not actually receive the notice, the section would not apply to you.

**Mr White:** But wouldn't the onus be on the sender of the notice to prove that the notice had been received?

**Mr Williams:** I would argue it would be actually the other way around. It would be up to the defendant to show they'd never received the notice.

**Mr White:** You're saying the onus would be on the defendant to say, "I did not receive that notice," and there would have to be some proof they had not done so.

**Mr Williams:** Yes. It says it's a defence to a charge that you didn't receive the notice, so it would be up to you to prove that.

**Ms Mitchell:** Just to clarify, I imagine what you're thinking is that if a retailer had a second conviction they would be knowledgeable that they had the second conviction and therefore would know that the prohibition, because it's automatic, would apply. But in addition, under clause 15(3)(b), "No wholesaler or distributor shall deliver tobacco to the place," and the wholesalers and distributors would need notification because they wouldn't automatically know a retailer had been convicted a second time.

**Mr White:** But the retailer wouldn't need that notification or another manager of the same store shouldn't need that notification.

**Ms Mitchell:** A fair question.

**The Chair:** With that, it's 4 o'clock and we do have two presenters. I know there are probably other questions, but ministry staff will be available as we go about our hearings. I'd like to thank you all for coming today and providing the presentation.

1600

#### PHYSICIANS FOR A SMOKE-FREE CANADA

**The Chair:** I call our first presenters, Physicians for a Smoke-Free Canada, if they would be good enough to come forward, and if one of you would be equally kind to introduce everyone for the purposes of Hansard and also for those who are watching at home. Welcome to the committee. We have all received a copy of your brief and attachments, and we have half an hour.

**Ms Cathy Rudick:** Hello. My name is Cathy Rudick. I'm the executive director of Physicians for a Smoke-Free Canada. With me are Dr Mark Taylor, the president of Physicians for a Smoke-Free Canada, and Dr Jack Micay, a Toronto-area physician who's also a member of our organization.

I'm just going to give a brief introduction the background of Physicians for a Smoke-Free Canada. We're a national organization established in 1985 as a registered charitable organization. We're a unique organization of Canadian physicians dealing with a single major health issue and clearly focused goals. This allows us to act and react quickly and decisively to deal effectively with the number one cause of preventable disease and death in Canada: the tobacco epidemic.

We have 1,400 physician members across the country, and we provide leadership for our profession in efforts to combat the epidemic of tobacco-related or tobacco-caused diseases. We are funded primarily by our individual members, with occasional small donations from outside interests, and to date we have never received government funding.

I will now pass it along to Dr Micay to give a brief introduction about the importance of this legislation and the prevention of tobacco-caused illnesses in Ontario.

**Dr Jack Micay:** The reason so many physicians have joined Physicians for a Smoke-Free Canada are these grim facts which I'll briefly review. Tobacco kills, in Ontario alone, 13,000 people a year; that's over one fifth of all deaths in Ontario. It's the cause of 30% of all cancers of all kinds, not just lung cancer, 30% of all heart deaths are due to smoking, and 80% to 90% of all lung



disease deaths are due to smoking. That is why I feel strongly about it and why the rest of my profession feels so strongly in support of this bill. I congratulate the government for presenting it and the opposition parties, hopefully, for supporting it.

The key to stopping this epidemic, and let's be honest and call it an epidemic, is to prevent children from coming on to the market, and to help smokers quit who want to quit. The first goal, in my view, is the more important one, and it's also the easier one. It's a very addictive substance. It's considered as addictive in clinical terms as heroin and cocaine, so it's a lot easier to prevent this addiction than to try to cure it.

This legislation is currently even more important because of what may be a pending drastic decrease in federal and maybe even provincial cigarette taxes. Price and taxes are the single most important factor in the decrease in smoking rates we've seen in Canada over the past 10 to 15 years.

Canada leads the world in this regard. We're looked on as a model by other countries, and this legislation before you today is also world precedent-setting and will send a signal around the world and will have repercussions around the world.

As I was saying, price is the biggest single factor, and if the price is going to be coming down dramatically, as there are indications it will be—there's talk of the price of a carton of cigarettes coming down from \$48 to \$20 to \$25—that is going to be an absolutely tremendous factor in bringing new smokers on to the market, and those new smokers are teenagers.

People don't start smoking after their teenage years—it's very unusual—and teenagers are the people who are the most price-sensitive. They have the least income and they're also the least addicted, so they're the people who are most influenced by price.

If the price is going to be coming down—I hope it isn't, but it may well be—restricting access becomes that much more important. That is one of the factors this bill addresses. We think this is critical in terms of saving hundreds of thousands of lives of young people.

**Dr Mark Taylor:** As Dr Micay has said, we're all very concerned about the impact of the potential tax decrease that may be coming up. Because of that, as you can imagine, the meagre resources of our organization have been very much tied up for the last week or so, doing what we can to fight this outrageous proposition, but we're going to do the best we can in making our presentation today.

We feel very strongly that tobacco does not belong in pharmacies. We support 100% the position of the Ontario College of Pharmacists, the governing body of the profession of pharmacy in Ontario, which has determined that tobacco should not be sold in pharmacies.

If pharmacies were retailers like any other, it would not be that critical to specifically prevent them from selling tobacco. However, for several reasons, pharmacies are not like other retailers. Pharmacists dispense medications which only they are allowed to sell. As fully trained health professionals, they are very much an integral part

of our health care system. When a pharmacy advertises, it portrays itself as a health care facility, not a convenience store. We all see that these days with Shoppers Drug Mart ads on television, their health watch system. Shoppers Drug Mart is not advertising itself as a convenience store or a grocery store; it's advertising itself as a health care facility. In that regard, it's inconceivable that they should be allowed to continue to sell tobacco.

Many pharmacists have long felt that it is inappropriate for them to be selling tobacco. In 1977 the Canadian Pharmaceutical Association passed a resolution at its annual general meeting that the CPhA should "encourage pharmacists to discontinue the promotion of tobacco products." The Ontario College of Pharmacists regulates the profession of pharmacy under the authority of the Health Disciplines Act. For years the college has been trying to have the sale of tobacco industry products eliminated from all pharmacies. In October 1990 the college voted to work as quickly as possible towards the elimination of tobacco sales in pharmacies. In June 1991 the college recommended that the Minister of Health ban tobacco sales in pharmacies as of July 1, 1993. The college also recommended that in the interim, Ontario pharmacists should take steps to progressively reduce and eventually eliminate promotion and advertising of tobacco in pharmacy premises.

The idea to ban tobacco in pharmacies is not one that we thought up and it's not one the Ontario government thought up; it's the request of the governing body of the profession of pharmacy. Not to respond to that request would be tantamount to taking away the authority of that governing body. The governing body of the profession has asked the minister to do something, and without a very good reason not to do it, in our view, the minister should do what the profession has asked.

In order to determine the level of compliance with the Ontario College of Pharmacists' recommendations, Physicians for a Smoke-Free Canada, with the assistance of many health organizations across Ontario, has surveyed and conducted onsite inspections of a representative sample of pharmacies in Thunder Bay, Sudbury, Windsor, Hamilton, London, Toronto, Kingston and Ottawa during January 1994. In total, 385 pharmacies were surveyed, 40% of which have eliminated the sale of tobacco industry products. Interestingly, among Pharma Plus and Shoppers Drug Mart pharmacies only one location had ceased tobacco sales. All the others are independent pharmacies. So in those pharmacies which are truly independent in this province, a very large number have chosen not to sell tobacco. That's not be confused with another organization which calls itself Independent but seems to be anything but.

Early findings in our survey have shown that over 84% of tobacco-selling pharmacies were in violation of the recommendation that by January 1, 1992, back bar displays be eliminated. In addition, 28% of tobacco-selling pharmacies displayed tobacco sponsorship advertising. Again, Shoppers Drug Mart and Pharma Plus more readily violated sponsorship advertising restrictions than the independents which are continuing tobacco sales.

Continuation of tobacco sales in combination with the



display of tobacco sponsorship promotional advertisements and promotional materials is of grave concern. Many pharmacies, especially among large chains, have extensive cosmetic counters. A very dangerous mixed message is sent to young women who are able to purchase tobacco along with health and beauty aids in an environment which readily advertises the *Matinée Ltd Fashion Foundation*, among others.

#### 1610

Some 23% of tobacco-selling pharmacies made tobacco industry products available from countertop self-serve units. Again, the large chains were more likely to make tobacco available without human intervention. Of the big chains, Big V has made the most progress towards the elimination of tobacco. Tobacco was not available from self-serve units and many had moved tobacco behind the counter to below-waist level. Three of 29 stores surveyed had removed tobacco entirely.

Those pharmacies that continue to sell tobacco products, particularly the chains, gave every indication that they had and would continue to ignore professional recommendations. Many education-based programs have been implemented over the years by various pharmacy bodies and yet the majority of pharmacies continue to sell tobacco. Clearly, a voluntary code for removal of tobacco industry products from pharmacy shelves will not result in compliance province-wide.

The college needs regulatory change to give it the teeth both for enforcement of the initial policy and for effective control over pharmacists, pharmacies and chains choosing to ignore the policy changes.

Those who argue against the elimination of tobacco sales in pharmacies claim that tobacco sales in pharmacies is natural and universal. Nothing could be further from the truth. Canada and the United States seem to be the only two countries in the world which permit the practice.

The code of ethics of the council of the Royal Pharmaceutical Society of Great Britain states that as of March 1987, members should not sell tobacco or tobacco products from registered pharmacy premises. To sell spitting or smokeless tobacco is considered professional misconduct. Similarly, tobacco cannot be sold in the pharmacies of Australia, Sweden, France, Belgium, Israel and Argentina, to name just a few.

To sell health and lifestyle products while selling tobacco is worse than hypocritical. For health professionals to be tacitly identifying tobacco as healthy gives tobacco an undeserved aura of safety. To identify cigarettes as products above reproach is absurd. There's an element of trust in the pharmacy business, as Shoppers Drug Mart executives have told us, and the trust is that a pharmacist is not going to put profit ahead of health and not going to promote addiction and death.

**Ms Rudick:** At this point, we'd like to counter some of the arguments that have been made by those in opposition to a ban on pharmacies. We'll begin with Dr Micay.

**Dr Micay:** One argument you'll hear is that tobacco is a legal product and that it's unfair to restrict sale of a

legal product from some stores and not from others. There are various examples that can be cited of legal products that are restricted in sale. One that comes to mind is pharmaceutical products. Prescription pharmaceuticals are a legal product and they're restricted in sale, and that's to the benefit of the pharmacists: They're only available in pharmacies. Other examples I can think of are firearms, chemicals of different kinds and so on. Even tobacco is a restricted product right now, because it's restricted to people who are of age. It's illegal, supposedly, for somebody under the age of 18 to buy it. So I don't think that argument washes at all.

**Dr Taylor:** An argument which certainly has some merit is that if tobacco isn't sold in pharmacies, smokers will just go to other stores. There's no one on this panel, and certainly no one in our organization, who's under the illusion that eliminating tobacco sales from pharmacies will stop everyone from smoking.

However, it is well known that one of the best ways to begin the restriction on the sale of anything is to limit the number of places in which it can be purchased. If a smoker has to delay his purchase of tobacco for even 10 minutes—he's at the pharmacy; he can't buy them there so he has to go across the street—that 10-minute delay will result in a reduced consumption of tobacco even in and of itself.

The other problem is that a large number of people who are tobacco addicts have to go to pharmacies to purchase their medications to treat their chronic bronchitis or emphysema or lung cancer or heart disease or peripheral vascular disease or cancer of the pancreas or cancer of the bladder. When they go to the pharmacy to get their medications, they're desperately trying to quit smoking, and right in front of them, which they can't avoid, are great big displays of cigarettes. Eliminating those cigarettes would be eliminating one source of temptation for those addicts who are desperately trying to quit.

**Dr Micay:** Another argument you will hear from some pharmacists, a minority of pharmacists I would say, is that pharmacists are in the best possible position to give smoking cessation advice. I think that's pretty obviously self-serving, and I would say that you can't argue at the same time that you have to sell tobacco to stay in business and that you're going to be telling your customers not to smoke. I'm not impressed by that argument and I hope you're not.

**Ms Rudick:** I'd like to add an anecdote to that. When our volunteers were doing the onsite inspections, prior to going out to investigate the stores that continued to sell tobacco products we called the pharmacies to determine whether they sold. The phone number I gave everyone was a phone number for the pharmacy itself, and not once was someone offered smoking cessation advice when they phoned to find out the price of a pack of cigarettes. People were directed straight ahead to the front of the store to get the price of the product.

**Dr Taylor:** The argument I personally find most contradictory is that pharmacies depend on tobacco revenue to stay in business. They usually make that argument immediately after they say the pharmacists are in a good position to promote smoking cessation advice.

On the one hand, they're telling us they must have the money from tobacco sales. On the other hand, they're telling us they discourage people from using the tobacco. Both of those cannot be true. No one is going to effectively discourage the consumption of a product on which their livelihood depends, so one of those is wrong.

The only literature I'm aware of on this topic was a survey done by the Canadian Pharmaceutical Association which found that of all those pharmacies that have voluntarily stopped selling tobacco, none have gone out of business because of the loss of revenue from tobacco and most of them suffered no loss of revenue at all.

**Dr Micay:** Another argument raised by the minority of pharmacists who continue to sell tobacco is that since tobacco's a dangerous drug, they're in the best position to control it. Again that strikes me as hypocritical and self-serving, and it really misses the point about tobacco.

Tobacco is harmful in even the smallest doses and it's lethal and it's addictive. When it's discovered that one of the prescription drugs being offered has lethal side-effects, it's taken off the shelves immediately by the drug companies and by the pharmacists. Why would they take away one poison and allow another poison, especially a poison that has no redeeming features? It's strictly a poison. It doesn't cure or treat any illness at all.

**Dr Taylor:** Pharmacists say they want a level playing field. I agree with that. There should be a level playing field, and the playing field that's level should be the playing field the governing body of the profession wants. The governing body of the profession of pharmacy in the province of Ontario wants the field level at zero tobacco sales, and that's where we should have it. Currently, all of those pharmacies in Ontario which have voluntarily stopped selling tobacco because of their own ethical concerns are now at a serious disadvantage. The field is not level for them. They're losing a tremendous amount of volume and business to those pharmacies which do sell tobacco. So let's level the playing field at a spot which is the ethical high ground and is also that ground demanded by the profession itself.

**Ms Rudick:** Tobacco sales in pharmacies should be completely banned. All efforts should be made to ensure that the pharmacy provision is enacted as expeditiously as possible. Tobacco-selling pharmacists have been well informed and provided with voluntary guidelines for removal of tobacco over an extended time frame. If the pharmacist chooses to be irresponsible and fails to follow the recommendations, based on an inaccurate assessment of the likelihood of continuing tobacco sales, they have only made a conscious decision to ignore the inevitable.

In addition, Physicians for a Smoke-Free Canada recommends that the definition of "pharmacy" be redefined to prevent direct exclusive access between pharmacies and retail areas devoted to tobacco sales. We propose the following definition:

"Premises in or in part of which prescriptions are compounded and dispensed for the public or drugs are sold by retail, as well as all contiguous retail space, whether under common ownership or otherwise, within the premises and whether used for the sale of health care products or otherwise."

**Dr Taylor:** We are open for questions now.

1620

**Mr Jim Wilson:** At the outset, I agree with much of what you've said, but you've obviously spent a great deal of time talking about the banning of the sale of tobacco products in pharmacies. For the record, to be as clear as I can, I see it not as a health issue but as a retail freedom-to-do-business issue. You talked about a level playing field. I've not heard any pharmacist make the argument that they are reliant strictly upon the revenues from tobacco sales, but they are to a great degree reliant on the flow of tobacco customers who may come in and buy other products.

Having all of my life been part of a family retail establishment, I can tell you we sold gas for many years; we never made any money on the pumps out front, but it brought people and traffic flow in. We probably sold a lot of things that weren't particularly good for you, including tobacco, but it brought people into the store to buy other products. In fact, we always put the post office at the back of the store so that people had to walk through the store. We also put tobacco sales at the back of the store so they had to walk through the store, and they would pick up other things along the way. I guess that's my bias.

But you make some very good arguments, and obviously the government has agreed with most of those arguments. I'm a bit confused as critic, though, because the College of Pharmacists came here when we were dealing with the sexual abuse legislation and told us it did not want to be responsible for its retail employees at the front of the store if they were to say something sexually abusive. At that time they told us they were a retail establishment. Now they're telling us that the whole bloody store is a health care facility. You can't have it both ways, is what I told the college. In one act, you don't want to be responsible for the high school student or someone who's your cashier at the front of the store, but now you're telling—and by the way, a lot of the people on the college are not retailers. They don't look at this as a business issue at all; they look at it as a health issue, as I'm sure you do.

I'm a little confused, having spent three years listening to all sides of this issue. You can't have it both ways. During the sexual abuse hearings, I took the stance that they were a retail establishment and that, unfortunately, they would be responsible for the clerk at the front of the store who may say something that has nothing to do with the pharmacy at the back of the store. That's the way that piece of legislation ended up. Call me stupid, but don't send me mixed messages, because I've got to respond to my constituents.

**Dr Taylor:** I'm in no position to explain the position of the Ontario College of Pharmacists on those two issues. You'll have to ask them. However, on the issue of bringing people into the store to buy other things, as I said, the only study I'm aware of having been done on this issue is the one by the Canadian Pharmaceutical Association. It looked at all those pharmacies which had voluntarily stopped sales, and of the 56 responding pharmacies that had eliminated tobacco, 59% had no loss



in sales or an increase in sales, 13% had marginal losses and 7% had moderate losses, but all 20% claimed to have recouped their losses after, at most, two years. Two pharmacists out of the total 56 have had some significant losses which have not been recovered.

**Dr Micay:** It should be mentioned that tobacco is a low-margin product. The experience of pharmacists who have taken it off their shelves and replaced it with higher-margin products is their bottom line doesn't suffer at all.

**Mr Marchese:** First, I want to make clear that I support the prohibition of tobacco from pharmacies. I want to be convinced, however, about accessibility being a factor in the diminution of smoking, because I'm not entirely convinced. I liken that to another situation, with young people who have a compulsion to eat. When you prevent them from eating or tell them they shouldn't, it becomes worse: They tend to develop more of a psychological dependence on it or sneak food when you don't see them; they find a way to feed the habit or the compulsion. I'm wondering if the situation is similar to smoking. If people want to smoke or have become addicted, does restricting the availability of cigarettes diminish the desire to find that cigarette package somewhere else?

**Dr Taylor:** I think there are two issues. First, on the issue of children, the fewer outlets that sell tobacco, the easier they are to control. The smaller the number of outlets which sell it, the less likely children are able to obtain tobacco. I'm not making the accusation that pharmacies sell to children; most of the time pharmacies are better than most corner stores on that issue, that's for sure, but the fewer number of total outlets, the better in terms of total sales.

I agree with your arguments about when you're actively trying to discourage the consumption of an addict. What I'm talking about is helping those people who have already made the decision to quit. Not being able to buy tobacco in a pharmacy is not going to convince anyone that they should quit. I'm talking about those people who have decided they want to quit, go into the pharmacy and see the cigarettes right in front of them. It's extremely tempting, because tobacco is so profoundly addictive. It's those people that I'm concerned about in that particular argument.

**Mr McGuinty:** Let me congratulate you on your work. I'm sure we've all heard about you for some time in terms of the efforts you've been putting into this. I assume on a voluntary basis. You do good on behalf of your profession.

You raised some compelling arguments with respect to supporting the ban on pharmacies. Something one of the doctors said struck me: the way you categorized the opposition parties. I want to make sure you understand our position here. Our position as members of the opposition is to raise all the arguments that are out there, even the minority ones, even the ones that some of us don't want to hear. That's why we do that. It's important for people out there who are going to suffer adverse effects. The government is going to remove a right from pharmacists, and I think it's incumbent on it to show why that should be done.

There's something I could ask you specifically, though. Section 9 outlines a list of places where you won't be allowed to smoke. Somebody raised something earlier that I thought was a good point. Why couldn't we add physicians' offices to that list?

**Dr Taylor:** Absolutely.

**Mr McGuinty:** There's something else while we're on that point. Sometimes you have to do a lot of reading while you're waiting to see your physician, and a lot of those magazines contain ads for cigarettes. That's something to consider.

**Dr Micay:** That's a problem that has been noticed by doctors. A number of doctors don't allow such magazines. There's a group of doctors in the United States that makes stickers they give to their members to slap on top of those ads, which ridicule the ads or make fun of them.

**Dr Taylor:** Of course Canadian magazines don't have any tobacco ads; they just have ads for all the tobacco-sponsored events going on. If the Ontario government chose to ban advertising of tobacco sponsorship in magazines and to include American magazines in that ban, it would be wonderful and I would support it 100%.

**The Chair:** On that note, I regret we have to stop the questioning. Thank you all very much for coming before the committee today, both for your written and oral presentations.

1630

#### ONTARIO RESTAURANT ASSOCIATION

**The Chair:** I call our last presenters for the day, the representatives from the Ontario Restaurant Association. Welcome to the committee. We have some healthy water and we're smoke-free.

**Mr Paul Oliver:** Good afternoon. I am Paul Oliver, president of the Ontario Restaurant Association. With me today is Rachelle Solomon, the association's manager of government affairs.

The Ontario Restaurant Association welcomes the opportunity to respond to Bill 119. As many of the issues raised in this legislation do not directly relate to the foodservices industry, the recommendations and comments put forward by the ORA will focus only on a few sections of Bill 119.

The Ontario Restaurant Association is a non-profit industry association which represents the restaurant and foodservice industry in Ontario. The association, which was founded in 1939, currently represents approximately 4,500 members representing thousands of foodservice establishments throughout Ontario. Our members are drawn from a wide range of establishments, both licensed and non-licensed, contract caterers, accommodation establishments, quick service restaurants and many other foodservice establishments.

The foodservice industry is a very diverse activity, feeding consumers in all circumstances ranging from fine dining to quick service establishments to factory cafeterias. In total, the industry includes what we would consider 11 distinctive characteristics.

The foodservice industry is dominated by small, independent operators who account for approximately



78% of the companies in the industry. Many operators within our industry, particularly the small, independent operators, are currently struggling to survive. Unfortunately, the cost of doing business in Ontario for the hospitality industry is increasing at an alarming rate, in particular the costs associated with the regulatory and compliance burdens placed on operators.

In January 1993, the ORA had its first opportunity to respond to the Ontario Ministry of Health's discussion paper on the planned legislation for the Ontario Tobacco Control Act. The ORA once again welcomes the opportunity to provide input, this time on Bill 119, the proposed legislation that was developed from the discussion paper.

**Ms Rachelle Solomon:** The first issue I'd like to talk about is the prohibition of smoking in designated places. We're very pleased that restaurants and bars have been exempted from prohibition of smoking in public places. The ORA believes that any changes to the foodservice establishment's smoking/non-smoking ratio should be left to the discretion of the operator and should be a reflection of customer demand.

The ORA believes that restaurant and foodservice establishments should not be viewed in the same context as public transit facilities or health care facilities, because the latter are mandatory entrance facilities, whereas in the case of restaurants a customer can make the decision about whether to enter.

Foodservice operators are very sensitive to making changes as a result of regulation or legislation; however, they are responsive to customer wants and needs. Some restaurants in Ontario have already converted to a 100% smoke-free environment as a reaction to the needs of their customer base. These operators have not been forced to change through regulations but have volunteered change, resulting in a progressive and positive response to the expectations of their individual customers.

The ORA feels that restaurants and bars should not be singled out as a culprit in the campaign against secondhand smoke. A much larger proportion of all smoking is done in the home. Children, senior citizens and pets are being placed at higher risk in their exposure to secondhand smoke in the home, because it is not as efficiently ventilated as a restaurant and because of the greater amounts of time spent in the home. A restaurant dining experience is a leisure activity that is purely voluntary.

We'd like to stress the importance of education rather than legislation in deterring smoking.

Our first recommendation is that the current exemptions for bars and restaurants in Bill 119 be maintained.

The second issue is controls relating to smoking tobacco. The ORA strongly opposes the section of the legislation which could ban smoking in restaurants. If the restriction on smoking is to be altered in the future, we believe it should be done through the legislative process, where there is political accountability and public input, and not through regulation. Therefore, we recommend the removal of section 9, paragraph 9, in which the government may prohibit tobacco smoking in a prescribed place.

With respect to municipal smoking restrictions in restaurants, we are concerned about the growing prevalence of municipal bylaws which place restrictions on smoking in restaurants. We believe that by allowing municipalities to make their own bylaws concerning smoking in public places, a patchwork of legislation is created which diminishes the effectiveness of the message, creates an administrative burden and creates competitive disadvantages. The ORA believes the provincial government should assume full responsibility for the regulation of smoking in restaurants and recommends that the provincial government work with the food service industry and municipal health officers to develop legislation which will set a provincial standard with respect to smoking which is applicable to all municipalities and is established as both a minimum and maximum for all municipalities in Ontario.

We also recommend the development of a working group comprised of government and industry representatives which would work together to develop a provincial standard with regard to smoking in restaurants and bars. We would be very pleased to be a member of a working group designed to achieve this end.

With respect to the prohibition of vending machines, we share the government's concern about the availability of tobacco products to minors through vending machines but believe a complete ban on vending machines goes beyond the government's stated objectives.

British Columbia recently introduced the Tobacco Product Amendment Act, which recommended that cigarette vending machines be permitted in premises where only adults are permitted. We see this as reasonable for Ontario since it would ensure that cigarettes are not being purchased by anyone below the age of majority. Therefore, we recommend that operators be permitted to place vending machines in age-controlled licensed establishments.

In terms of both operators and employees, we support the placement of cigarette vending machines in areas where the public is not permitted or in areas accessible only to restaurant employees, such as the kitchen area or back-of-the-house facilities. By permitting vending machines in non-public areas, it would allow for an element of control by the establishment to ensure that any customer who wishes to purchase cigarettes is of legal age to do so, as only waitpersons would have access to the vending machine. This would also help the security to the employee. Vending machines help to reduce the possibility of threats of physical violence by persons committing break-ins or robberies or having the intention to do so. They act as a deterrent against crime when compared to simply having cigarettes behind the bar. Therefore, we recommend that operators be permitted to place vending machines in areas not open to the public.

In conclusion, we appreciate having the opportunity to present our opinions on Bill 119. The initiatives under the province's tobacco strategy are progressive in that they augment current municipal initiatives and trends towards good health and a clean environment. The province should be congratulated for not taking a prohibitionist approach but for establishing reasonable guidelines that

prevent Ontario youth from starting to smoke.

**Mr Wessenger:** The first question I have is with respect to your proposal concerning the provincial setting of standards in terms of smoking and non-smoking aspects of restaurants. Would you prefer a provincial standard as opposed to the varying municipal standards even if that meant a standard at the higher level, say at the high municipal level?

**Mr Oliver:** I think what you would need is further consultation between the industry, municipal health officials and the province. We would like to see a standard that's set as the maximum and minimum. We don't want to see it as the bottom and that municipalities can still randomly at will exceed that level. What we have now is situations where in one municipality it could be 30% non-smoking and right across the street it could be 50% non-smoking, so the operators have different playing fields. We're currently surveying our members on what is the most workable percentage for their establishments, but what we would like to see is that the whole responsibility for smoking in restaurants and setting that standard be taken over by the province and out of the hands of the municipalities.

**Mr Wessenger:** Basically, you'd favour that the whole matter to be dealt with at the provincial level as distinct from a municipal level.

1640

**Mr Oliver:** Yes, because it will eliminate the competition. Also, for chain operators, if they've got 20 different locations in 20 different municipalities, they've got 20 different rules to follow. We think moving to a provincial standard would reduce resistance from the industry because of the competitive aspects and that you'd get a lot more industry support for it. Now we have municipalities where it's almost that this is the issue when their agenda is slow, that they move with this, and then the inequities in the system become very prevalent.

**Mr Wessenger:** The second question relates to the ventilation mechanism study I understand you've done. Have the recommendations of that study been implemented in any of the restaurants and do you have any idea of the cost aspect of it?

**Mr Oliver:** The cost aspect is certainly a major concern, because it varies between establishments. With a single, standalone, one-storey establishment, it's much easier to do it. We've distributed it widely within the industry and encouraged operators to adopt it. We've certainly encouraged people designing new restaurants to use it as a basis, because if they're starting from ground zero putting in a new ventilation system, modifications outlined in our study would be easily accommodated.

**Mr Wessenger:** Are there any special considerations? You're mentioning ventilation standards, that you believe they should be established. Do you think your study would be beneficial to other situations where people are smoking, situations other than restaurants?

**Mr Oliver:** There may be limited application; I'm not sure. We've based it on the restaurant industry, different air pressure in the smoking area versus the non-smoking area and following the air flow. My understanding is that

most workplaces now have separate ventilated rooms, or a lot of them do. We're certainly willing to share it with anyone who's interested in it.

**Mr McGuinty:** Thank you for your presentation. I'm interested in your section dealing with the vending machines. The government seems to feel it would be impractical or unreasonable to expect that your members would be able to properly supervise a cigarette vending machine. I'm wondering how you respond to that.

**Mr Oliver:** In a lot of establishments, the control is there now for people purchasing beverage alcohol and other age-accessibility issues; we're talking about permitting them into licensed establishments, into an area supervised by an employee.

One reason we're concerned is that a lot of establishments use the vending machine as both a security and control mechanism. To keep a dozen boxes of cigarettes behind the bar certainly encourages some type of criminal activity, even just breaking into the establishment after it's closed to access that. The vending machine acts as a barrier to that, and it also means an employee does not have to deal with the product or does not have to handle it where they would be having a dozen different boxes under the bar. That's been raised as one of the major concerns operators have.

We think there are two ways to handle it in establishments that don't have age-controlled accessibility: that it would not be available to the public but would be accessible to the employee if someone wanted to purchase a box of cigarettes; and in an age-controlled establishment, it could be by the bar or accessible to the public provided there is an age mechanism in entering the establishment.

**Mr McGuinty:** How likely is it that someone under the age of 19, in an age-controlled licensed establishment, would have access to a cigarette vending machine?

**Mr Oliver:** We would see it as very limited, if not non-existent. For example, to enter a nightclub that's age-controlled, they would have shown their identification or had some screening process to enter the establishment. If they're going to put forward fake identification to get into the establishment, they're going to do anything to get it, whether going into a variety store—that's not going to be a barrier to them.

**Mr Arnott:** Is it fair to say that the Ontario Restaurant Association supports the bill in principle as it is now?

**Mr Oliver:** We've commented on specific sections that impact the restaurant industry. We certainly support the fact that it hasn't put more smoking restrictions on the restaurant industry relative to consumer demands. Generally, the bill has fairly good support in terms of limiting the availability of tobacco products to young people. You'd never catch me arguing against that.

**Mr Arnott:** I'm also interested in section 9. You expressed concern about paragraph 9, which leaves open the possibility of the government arbitrarily adding restaurants to this list at some point in the future. I asked earlier what the rationale is or the thinking that was applied to generate the list as it exists. Hopefully, you'd get an indication of what the government's plans are in



the future if you could understand its thinking.

I didn't really understand the answer, but perhaps you've given a fairly good explanation: that these are premises you can walk past, in theory, as opposed to others you have to enter. But I share your concern: I think we understand that this isn't the end of the line in terms of tobacco regulation, an issue that's been with us for 35 years, and new restrictions are applied every few years. I share your concern in that respect.

**Mr Oliver:** Certainly we don't see this as the end. We see tobacco legislation, restrictions on smoking and access to tobacco, evolving to reflect consumer preference or social changes. But if we're going to make major changes to where you can smoke or purchase the product, we think it should come back to the legislative process so people like the committee members here would have input, the public would have input. We wouldn't want to see these decisions being made in-ministry, where there isn't political accountability. We think hearings like this are very beneficial to the public policy process, and making major changes should come back here. It may take a few months longer to take it through the legislative process than doing the regulation, but we think it improves the process and improves the legislation itself.

**Mr Arnott:** And accountability as well. It's a valid point.

I have another question about your position on municipal restrictions. You suggest that there should be a province-wide standard applied as opposed to patchwork standards, municipality by municipality. Are there any jurisdictions you're aware of in the United States or in Canada that have either a state-wide or province-wide regulation of tobacco use?

**Mr Oliver:** I don't have a list offhand, but many of the states in the US are looking at it or have moved in that direction already. Our counterpart associations in the United States have endorsed that concept because it creates a level playing field for everyone, and it also addresses the needs and concerns of chain operators that are operating in multijurisdictions in Ontario.

**Mr Arnott:** There is an issue of local autonomy that would come into play there, and that would change if indeed what you're suggesting were—

**Mr Oliver:** That's one of the reasons we have suggested a multistakeholder group with municipal officials on it, so that they would have an input into developing that with the industry and with the Ontario Ministry of Health and the provincial government.

**Mr Arnott:** Another relevant point with respect to this discussion as it affects restaurants is that the owner or the manager of a restaurant has a direct interest in making sure that commonsense rules are applied with respect to smoking, because a non-smoker may very well not want to have smoke blown in their face during the course of enjoying a meal and might not come back if that happened. I think that's something the government has to consider as well, that self-regulation with respect to restaurants is very likely the best way to handle this issue.

**Mr Oliver:** If you survey restaurants, depending on

which sector of the industry they're in, certainly we've seen a lot that go well beyond what the municipal legislation is. For example, Taco Bell introduced a 100% ban recently. Tim Horton Donuts has a target of 100 non-smoking stores before year-end. They're doing it because the consumers are telling them to do that, just as our industry brought in lighter meals during the 1980s because the consumer wanted a healthier choice, and our industry is moving that way.

As you say, the customer has the final say about whether they want to come back to our establishment or even want to arrive at the establishment. Customers don't hold back when they tell the operator their comments.

**1650**

**Mr Tony Martin (Sault Ste Marie):** On a tangent to the health issue, which is primarily what this is about, I'd like to focus a bit on the economics of doing business as a restaurateur in today's world. For a time before I had this job I worked with teenagers in various forums, and smoking brought with it attendant difficulties in terms of burned carpets and a terrible mess that needs to be cleaned up and this kind of thing. Is there anything in this legislation that would give you some platform from which to go into a development in your industry that would be helpful re that kind of consideration and the cost it incurs?

**Mr Oliver:** Currently, operators can make the choice. If they want to put further restrictions on smoking to prevent that or introduce a complete ban, there's nothing that prevents them from doing that. The proposed legislation would not put a further restriction on an operator who wanted to do that. I don't think there's anything in the legislation that would help them address that issue, but I certainly don't see anything in there that would hinder them from addressing the issue themselves.

**Mrs O'Neill:** I want to go back to the vending machine and what you've said on the bottom of page 7. You have suggested to put the machine in a certain place. It wouldn't be the first place I'd think of, so you obviously must have a reason from looking at your industry and from consulting with restaurateurs. Could you say a little about why you have chosen that particular—

**Mr Oliver:** For putting it into bars and restaurants? Because there's an age control.

**Mrs O'Neill:** But at the bottom of page 7 you're talking about the actual location.

**Mr Oliver:** That was a separate proposal. A lot of establishments in the hospitality industry use the machine, and it's often the employee who accesses the machine because someone will ask for a certain type of cigarette or a pack and they will get the money from the customer and go and access it; they use it as a control management mechanism in the establishment. But it also eliminates the potential of having a whole bunch of cigarettes exposed that someone from outside the establishment could enter to try to seize. They use it as a mechanism because the owner-operator is the only person who has access to the machine, so it acts as a secondary barrier to a violent crime or some type of crime to access it. It's almost a management tool.



We're suggesting that operators should still be allowed to use it as a management tool. In this case, we're proposing that it be away from public access, in the kitchen or in the staff-only area, the same way as a dispenser for other products in the establishment should be allowed. Our reading of the act would suggest that even if it weren't available to the public and were in a secured area, you still could not have a vending machine. A lot of operators in our industry have purchased these machines, invested money in them and don't even have them available to the public now. We don't think further restrictions should be placed on those operators.

**Mrs O'Neill:** Have you had any response to this—I don't know whether it's a problem or a solution—from the government on this issue?

**Mr Oliver:** We are raising it here as part of the consultation process. We raised our views during the discussion paper process on vending machines and now we're putting forward what we think is a manageable recommendation.

**Mrs Haslam:** My question is along the same line. You state it would be put in back-of-house facilities or the kitchen area. Do your members generally agree with this, or do they have other options such as selling from behind the counter?

Second, what about underage people who work in the kitchen or who are servers? Not all restaurants hire 19-year-olds. I ought to know, because I've got two children who worked in restaurants for a time. When I go into a take-out restaurant to order, the people in the kitchen and back-of-house area are not older than 19; some are 18. That then begs the question of a friend saying, "Get me cigarettes from the vending machine at work." The access is still a problem from the youth point of view, which is what I'm very interested in.

Third, do you see a difference in handling this particular situation in the bars, taverns, those types of facilities, versus family restaurants or other facilities?

**Mr Oliver:** From the surveys we've done of members, very few of the family-style restaurants retail tobacco products and they're actually shrinking their smoking areas dramatically.

**Mrs Haslam:** So this wouldn't be a solution for them.

**Mr Oliver:** It hasn't been raised as a problem for those. It's the traditional licensed establishment, nightclub, tavern-style operation. Tobacco sales and children is a concern, but it's about the same concern you'd have that there's no age minimum in a variety store that sells cigarettes: You could have a 15-year-old in a variety store selling cigarettes. We think the chances of it happening would be the same in a restaurant as in a—

**Mrs Haslam:** But the vending machine doesn't ask for identification as a clerk in a convenience store must, by law. A vending machine does allow access without accountability.

**Mr Oliver:** Possibly, but I thought you were asking about the issue of an employee under the age of 19

accessing it themselves.

**Mrs Haslam:** That's correct.

**Mr Oliver:** The places we would see this happen would be in licensed establishments predominantly. It is the server, and in Ontario they have to be of a certain age to serve beverage alcohol. We think those regulations or restrictions can be placed on it to address those concerns.

**Mrs Haslam:** Versus selling across a counter.

**Mr Oliver:** Yes. We're not talking about this type of thing being applied in a Burger King or a McDonald's. They don't sell tobacco now and we don't anticipate they will in the future. It is the bar and nightclub type of establishments, which have a clientele over the age of 19 and have a workforce that's predominantly over 19.

**Mrs Haslam:** But do they see this as being better than across the counter, where there is more accountability? I'm concerned about accessibility and accountability for selling cigarettes to minors.

**Mr Oliver:** There's certainly a major concern about selling it over the counter, because we've seen a dramatic increase in violent crime pertaining to cigarette sales. To have a dozen cartons open behind the counter raises that issue and it raises a major concern on both the employee and operator sides. The chance of someone holding up a machine to get a hundred loonies out of it is very limited compared to someone holding up a bar operator. Also, selling tobacco, because of the cost of it now, for some establishments would make up as much as alcohol sales.

**The Chair:** Thank you both for coming before the committee this afternoon. We appreciate it.

Before adjourning, members, two things: First, you have a copy of the agenda for the next several weeks, if you could check that over, particularly in terms of the other places we'll be: London, Sudbury, Thunder Bay and Ottawa. The other point is that we have requested of the House leaders that one of the four clause-by-clause days be changed to a hearing day. If we do that, we will be able to hear from everyone who requested to appear before the committee. The request we've made is that we sit on either Wednesday, February 23, or Thursday, February 24. As soon as we get word from the House leaders, I'll let you know. It would mean the week of March 7 would be three days for clause-by-clause instead of four.

**Mrs O'Neill:** When we have to come early to Toronto, for instance, when we go to Thunder Bay, will be given the exact time and flights of when we're going to be connecting?

**The Chair:** That information should have been sent to your office.

**Mrs O'Neill:** We have all the flights already?

**The Chair:** Yes. If there are any problems, by all means have your staff talk to the clerk.

**Mrs Haslam:** Is this room secure?

**The Chair:** No. Take your material with you.

The committee adjourned at 1700.







## CONTENTS

Monday 31 January 1994

<b>Tobacco Control Act, 1993, Bill 119, <i>Mrs Grier</i> / <i>Loi de 1993 sur la réglementation de l'usage du tabac</i>, projet de loi 119, <i>M<sup>me</sup> Grier</i> .....</b>	<b>S-703</b>
Ministry of Health .....	S-703
Hon Ruth Grier, minister	
Larry O'Connor, parliamentary assistant to the minister	
John Garcia, director, health promotion branch	
Dr Richard Schabas, chief medical officer of health, Ontario	
Brenda Mitchell, manager, tobacco strategy unit	
Frank Williams, legal counsel	
Physicians for a Smoke-Free Canada .....	S-725
Cathy Rudick, executive director	
Dr Jack Micay, member	
Dr Mark Taylor, president	
Ontario Restaurant Association .....	S-729
Paul Oliver, president	
Rachelle Solomon, manager, government affairs	

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \*Chair / Président:** Beer, Charles (York-Mackenzie L)  
**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)  
Carter, Jenny (Peterborough ND)  
Cunningham, Dianne (London North/-Nord PC)  
Hope, Randy R. (Chatham-Kent ND)  
**\*Martin, Tony** (Sault Ste Marie ND)  
**\*McGuinty, Dalton** (Ottawa South/-Sud L)  
**\*O'Connor, Larry** (Durham-York ND)  
**\*O'Neill, Yvonne** (Ottawa-Rideau L)  
Owens, Stephen (Scarborough Centre ND)  
**\*Rizzo, Tony** (Oakwood ND)  
**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Arnott, Ted (Wellington PC) for Mrs Cunningham  
Haslam, Karen (Perth ND) for Ms Carter  
Marchese, Rosario (Fort York ND) for Mr Rizzo  
Wessinger, Paul (Simcoe Centre ND) for Mr Hope  
White, Drummond (Durham Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Sterling, Norman W. (Carleton PC)

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service  
Gardner, Dr Bob, assistant director, Legislative Research Service

CA20N  
XC12  
- 577



S-30

S-30

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 1 February 1994

# Journal des débats (Hansard)

Mardi 1 Février 1994

## Standing committee on social development

Tobacco Control Act, 1993

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 1 February 1994

The committee met at 1003 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. We begin our second day of hearings by the standing committee on social development into Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to regulate its Sale and Use by Others.

## ONTARIO CAMPAIGN FOR ACTION ON TOBACCO

**The Chair:** I'd ask the representatives from the Ontario Campaign for Action on Tobacco if they'd be good enough to come forward. As they do so, I just note for committee members that we have received from the research group copies of the press clippings with respect to yesterday's opening hearings.

Gentlemen, welcome to the committee. If you'd be good enough to introduce yourselves, then please go ahead with your presentation. We have half an hour.

**Mr Michael Perley:** Good morning, committee members. My name is Michael Perley. I am the director of the Ontario Campaign for Action on Tobacco. With me is John Ronson, the chair of the campaign and also a senior volunteer with the Canadian Cancer Society. We have a considerable brief, which has been distributed to you, that we would like to summarize the main points of, and also respond to your questions.

First, a brief word on the Ontario Campaign: As you probably already know, we are made up of the major health charities in the province, notably the Canadian Cancer Society, Ontario division, the Heart and Stroke Foundation, the Lung Association of Ontario, the Non-Smokers' Rights Association and the Ontario Medical Association. At a conservative estimate, I'd say our groups represent in the neighbourhood of 300,000-plus volunteers and physicians and medical professionals across the province, all of whom share the concern we all do about the effects of tobacco and the need to control it.

Our campaign is based on four pillars, if you like, four main objectives that we want to see enshrined in legislation.

First is the control of sales to minors. We have placed a special emphasis on the need for a retailer licensing system, which we can perhaps discuss a bit later.

There is a need for plain cigarette packaging. This is an excellent way to break the link between the tobacco companies' sponsorship advertising, which you discussed briefly yesterday, which they've used to avoid the

Tobacco Products Control Act federally, and also an excellent way to make the product less attractive to young people, as Canadian Cancer Society research published in January shows.

You've heard a great deal already about the ban on sales in pharmacies. You'll certainly hear more, particularly, I think, in the weeks ahead, from pharmacists who've successfully taken tobacco out and have not suffered. On the contrary, in some cases I think you'll see evidence that their financial and business position has improved subsequent to removing tobacco from the pharmacy. Also, there are the many ethical and professional issues you've heard discussed yesterday already. I won't summarize them here, except to say that we very strongly support this ban. It's one of our four main pillars, and in fact we feel, and we'll recommend later, that the legislation gives too long a time period for the implementation of that ban. We'll discuss that briefly later.

Finally, and no less important than the other items, is the need to further control environmental tobacco smoke. There are two aspects to this, one respecting Bill 119 and one respecting another piece of legislation. The public places designations in the bill are important. We'll have comments on how that might be improved. Also, though, the Smoking in the Workplace Act, which is not under the jurisdiction of this committee at the moment but which is an important vehicle for controlling smoking in the workplace, we feel needs to be strengthened. We know the Ministry of Health is interested in this. The Ministry of Labour is interested in this. I'm sure this committee will be interested in considering a recommendation along those lines, and Mr Sterling, whose long record on this issue is well known to us all, I'm sure will be particularly interested in this.

Those are the four main areas of our campaign. We'd like to very strongly congratulate the government for the initiative that it's shown in bringing this world-precedent-setting bill forward. I don't think anyone in the health community feels this bill is anything less than world-precedent-setting in its present form.

We'd also like to congratulate the opposition parties for their assistance in moving the bill forward through the legislative process to this point. We obviously have some disagreements over the substance, which we're all prepared to roll up our sleeves on, I think, and already have, but I think in terms of the overall progress of this bill through the Legislature, they're to be commended as well, and the government for its strong support of a strong initiative.

I'd like to very quickly summarize, realizing that our brief is probably somewhat more detailed and technical than other briefs you may get, because we've gone right down to the level of some language changes, some technical amendments. We've really given the bill a thorough going-over and have a number of what we've

called initially technical or language-related amendments, which we don't believe are controversial. We hope they won't be, at any rate. These concern:

The prescription of identification required to purchase tobacco industry products. We think that can be better defined in the legislation and we have a recommendation in respect to that issue.

How a pharmacy is defined: This came up yesterday. We feel that a pharmacy can be better defined to prevent the possibility that was raised yesterday of easy access between a pharmacy and contiguous retailer who may sell tobacco products, whatever their relationship.

The definition of health warnings and other information required on signs and sponsorship advertising under sections 5 and 6: At the moment warnings only are required. We suggest a change to allow for other health information; for example, a quit-smoking telephone number or information of that type to be put on these signs. I think that should be a way to increase the information value of them. We don't think it will be controversial to the committee.

Make public the reports to be published about the activities of wholesalers under section 8.

The definition of school grounds: Again, you've already discussed this yesterday, and I think there's unanimity that we need to make sure that a school, as defined in section 9, includes the grounds. I sensed there was agreement yesterday on this matter.

#### 1010

Somewhat more substantive suggestions we have to make concerning some amendments, which again we hope would be non-controversial, but they're not simply technical or language-related, particularly concern the control of tobacco paraphernalia. These paraphernalia are things like tobacco papers, tubes and in particular the cigarette cases that are now available with manufacturers' current logos and designs on them, which the manufacturers may more widely distribute if the packaging is controlled to limit the amount of design and colour and what not that's on there now that allows the link between the sponsorship advertising and the packaging. So we have a recommendation concerning that.

I will just very quickly summarize the items here—I won't discuss them because of time limitations—and then please question us on any aspect you're concerned with.

The banning of kiddie packs, that is, packages of cigarettes of less than 20: I think we're all concerned about that, a lower-priced package with fewer cigarettes, and not only the 15s that are available now, but there are fives that have been test-marketed in Ontario and elsewhere. These bring cigarettes within the price ambit of young people, and we think they're a problem. The packaging section should allow this by regulation, but you may want to make it more specific.

Types of identification: They're prescribed under the liquor licence legislation. We suggest using the same prescription for identification.

Control of point-of-purchase displays: These are the countertop displays that you find in many drugstores and convenience stores and in aisle displays as well. I think

you'll hear evidence, certainly from some of our colleagues in pharmacy, that they, in their view, encourage shoplifting and theft, provide an excellent advertising vehicle for the industry and are not designed to encourage reduction of smoking or invisibility of the product, by any means; quite the contrary.

I mentioned the limitation of the time exemption for implementation of the pharmacy ban. Very simply, the college requested the legislation in June 1991, as you've heard, and recommended a series of progressive steps under which pharmacies should reduce the visibility and availability of tobacco products at their counters.

Now, anybody who's gone into a Shoppers Drug Mart store, in particular, recently, or many other pharmacies, knows perfectly well that not only have they not taken the tobacco out of their stores but it's just as visible and just as available as it ever was. They've taken no action under the voluntary ban. At the same time, you hear opponents of the ban argue that a voluntary tobacco reduction program is what the profession should be doing. So the two don't add up, just as the counselling versus going-out-of-business argument doesn't add up.

So we would strongly recommend that given how much time the profession has had—and many pharmacies, and you'll hear from many of them during these hearings, have done something about it, but we feel that given the amount of time they've already had to do this, nearly four years probably by the time we get into the next sitting of the Legislature, we should simply give them three months from the date of proclamation of the act, which won't be for several months yet. Let's remove this item.

Another thing which is substantive and we hope will be non-controversial and will aid the Legislature very much in evaluating Bill 119's success ultimately is an annual report we would recommend that the chief medical officer of health be required to make to the Legislature on the effectiveness of the bill, how its various provisions are working, how it's contributing to the achievement of the provincial tobacco use reduction targets you're all familiar with and how we're doing on enforcement: Have we got enough personnel? What are the charges like? What are the fines that are levied? Are they serving as effective deterrents? I think that would be a useful way for the Legislature to keep close track of the success of this landmark bill.

We think that conviction under section 16 with respect to breaking the terms of the act should have a greater prohibition than simply a six-month sales ban for a third or subsequent conviction. If you get a wholesaler or retailer who's repeatedly defying this legislation, we strongly recommend that you increase that prohibition on a third or subsequent offence beyond six months; probably to a year would be effective, we feel.

Some qualifications on the use of tobacco by aboriginal persons: Our concern here is strictly that such uses do not expose anyone else involuntarily to secondhand tobacco smoke, and we say that in the context of secondhand tobacco smoke or environmental tobacco smoke, ETS, as it's called, as a known human carcinogen, a group A carcinogen as defined by the



Environmental Protection Agency in the US. This is a very serious matter, exposure to this material, and we feel that uses which should be appropriate under spiritual tradition should not, nevertheless, be able to negatively affect the health of other persons involuntarily.

We have some other substantive amendments which we'd like to discuss with the committee. These are things that we think need to be done, need to be addressed. We would advocate that you consider them. We would like to discuss them with you. We would like, if you're interested, to prepare additional material on them. We'd like to put them on the table at this point. For various reasons, our groups feel quite strongly about them.

The first is a ban on spitting or chewing tobacco. We've presented some summary evidence in our brief about the negative health consequences of that material. It's not of epidemic proportions in Ontario at this point. We have an opportunity to cut it off before it really takes hold, as it has in the United States. There are obvious exemplars out there in the sports field of sports players who use it. That makes it very attractive to young people, as we all know. We feel that given the kind of damage it can cause, oral cancers being the most prominent type, there's no redeeming value in this material at all, quite the contrary, and we should do something about it sooner rather than later. You'll be hearing in more detail about this from medical experts as the hearings proceed.

We think, concerning the designation of public places where smoking is now prohibited under the bill, that this issue should more properly be addressed by simply banning smoking in public places, all public places, except where specifically exempted by regulation. This is called reversing the onus of this provision.

The reason we say this is that we think, given the seriousness of this issue from an environmental tobacco smoke point of view, direct use point of view, we all know the statistics, it's about time that the people who want to allow this, want to encourage it, want to promote it, want to expose others involuntarily to it should be forced to come forward to the ministry and explain their reasons why their proposed use is harmless or will not affect anyone unnecessarily or involuntarily. I think this would be a very effective limitation on public place exposure by many people to environmental tobacco smoke.

We also referred earlier to the Smoking in the Workplace Act and the need to strengthen it. This isn't something this committee would deal with, we understand, directly, but you may want to recommend that the Ministry of Labour and the Ministry of Health get together on this and move forward. There seems to be some consensus that this needs to be done. So it's important.

In light of the controversy that's erupted the last few days over the tax issue, just very quickly, because I see our time is shrinking rapidly, if the tax reductions happen, there's no question by anybody's estimates that smoking among young people will go up dramatically. We appear to be headed for greater numbers of young people entering the market than currently enter the market under the proposed tax rollbacks that may happen. We

hope they won't.

If they do, control of retail sales becomes even more important. We now have a statutory prohibition in this bill. We feel that if the tax rollbacks occur and the greater numbers of young people come into the market as a result that are predicted by the Department of Finance and others, we definitely will need retailer licensing. We have done a lot of work on retailer licensing. We've drafted language of a system. We've investigated it. John will speak about it in a moment. We think that you'll need to look at that but, again, in the context of tax rollbacks.

#### 1020

Finally, again if the tax rollbacks occur, the need for plain packaging requirements sooner rather than later. This will be an extremely important issue in terms of deterrence of young people. The cancer society's research shows it. Also, it makes it a lot easier to control what contraband there is.

Forgive me for taking a lot of time there, but I wanted to run over all those items for you and refer you to our brief where there is substantive discussion of them all.

John Ronson will now present to you on some of the aspects of the bill, particularly plain packaging, ETS and licensing.

**Mr John Ronson:** I'm going to cut this short because I know that a number of members of the committee have questions.

Let me just say that, like Michael, and speaking on behalf of the cancer society and the other agencies involved with the OCAT group, we congratulate the government and we congratulate the opposition parties for really treating this as a non-partisan issue. This issue is far too important for partisanship. We congratulate all three parties for the responsible debate that has gone on to date and that I'm sure will continue as this bill goes through the committee stage and back into the House.

As Michael has mentioned, we are particularly concerned, in light of what's been happening in Ottawa over the past week or so, with the whole issue of a tobacco tax rollback. Were that to occur, it would destroy or seriously compromise the strongest of the four pillars, in our view, which is the effect of price, particularly on consumption by teenagers. We know that if we stop them as teens, they won't start. If that happens, that is going to reinforce the need for a very strong provincial response in the form of this bill. We would urge the committee to report back to the Legislature not only with the bill as it's currently drafted, but with some of the substantive amendments that Michael has described in his presentation.

The presentation, as he's mentioned, goes into great detail with some specific drafting suggestions, and we would be pleased to offer our services to work with you and with legislative counsel as you work through that process. There is information on plain packs and recent cancer society-funded research, and if members of the committee would like a copy of that research, we will certainly provide it.

I think I'll stop there to give you plenty of time to ask questions.



**The Chair:** Thank you very much. We do have a little time for questions. I'm going to ask members if they can put their questions into one question. I have Mr McGuinty, Mr Wilson and Ms Haslam.

**Mr Dalton McGuinty (Ottawa South):** Thank you both, Michael and John, for your ongoing good work in an area which is a matter of grave concern to all of us. I use the word "grave" advisedly.

Thank you for your very comprehensive report. I particularly like your recommendation dealing with compelling the provincial medical officer to report annually as to how we're doing with respect to reducing smoking and how the bill is working.

I want to focus quickly on the two more controversial aspects and profit from your presence here and allow you to comment on that.

First of all, I don't think there's anybody, certainly whom I've met or spoken to or heard from in relation to this matter, who is against making it harder for young people to start smoking. And I think most people are prepared to implement reasonable measures to ensure that those who do not choose to do so aren't exposed to secondhand smoke.

Given that, and given that as the thrust of the bill, please tell me how banning sales in pharmacies will assist in that regard.

**Mr Ronson:** Let me lead on this one, Mr McGuinty. We are not suggesting for a minute that the ban on sale in pharmacies alone is going to have a dramatic impact in terms of either stopping teenagers from smoking or stopping anyone from smoking.

In our view it comes down to the fact that the Ontario College of Pharmacists, which is the regulatory body for pharmacy in this province, has stated publicly and has asked the government and supports the position that pharmacists are members of the health care team; they are primarily members of the health care team and only secondarily are they retailers. That's the fundamental choice that pharmacists have to make. We support that and the member groups of our coalition support that, particularly the Ontario Medical Association.

If pharmacists want to be full players on the health care team, then they have to make the choice. They can't at one end of the store be selling tobacco products which, when used exactly as intended, are lethal, and at the other end of the store be selling the patches and selling prescription drugs that are designed to make people well. It sends out a very mixed message.

We're not suggesting it's going to have a dramatic effect on reduced consumption, and I think that's frankly a bit of a red herring. What we are saying is that we need a comprehensive approach, and I think the government is to be commended for a comprehensive approach. What we're trying to do is reduce the social acceptability. That sends out a very mixed message when so-called health professionals are doing both.

**Mr Jim Wilson (Simcoe West):** I want to thank you for your presentation and the information you've provided to us over the years.

As you've rightly said, all parties agree on most

aspects of this legislation and, from my point of view, as Mr McGuinty has just stated and as you know, expressed consistent concern with respect to the prohibition of the sale of tobacco products in pharmacies.

I dug out the Hansard last night, because everyone keeps quoting the college of pharmacists, and I mentioned this yesterday. On the November 29, 1993, the college of pharmacists, in a submission regarding the sexual abuse legislation, appeared before this committee and asked us to only consider their customers as patients when that person who walks into their store deals directly with the pharmacist. In other words, they were concerned that we would consider them a complete health facility and that if someone were to say something derogatory, if the clerk at the front of the store—and I know Michael heard this argument yesterday—were to make an inappropriate remark of a sexual nature, somehow, because they were in the pharmacy, there would be a charge against the pharmacist or the pharmacy as a result of the action of an employee.

What I took from that submission was a recognition from the college of pharmacists that indeed they are retailers and that it's a significant part of their business and that they considered only that contact with the customer, directly between the pharmacist and the customer, to be the patient-pharmacist relationship. We were told that normally occurs at the pharmacist's counter and that the rest of their operation was essentially a retail operation. As a retail operation, I think they wanted us to respect the fact that they pay retail sales tax, that they're considered a retail outlet and that they wanted, as the language is, a level playing field with all other retail outlets, including the right to sell legal products such as cigarettes.

You've had 24 hours to think of this, so I'm sure you have a great response. But I was somewhat confused because they were concerned at that time, at the end of the day, I think, that the gist of the bill ended up being that they were considered a health facility, yet the college at that time, I again stress, wanted to make sure that we knew they were also retailers selling legal products.

**Mr Ronson:** I'm going to turn this to Michael, but let me respond quickly to the level playing field argument. That cuts both ways. Pharmacists have a monopoly on the sale of prescription drugs. Let's not forget that. They have a monopoly in that area. So the level playing field argument cuts both ways. But I'll let Michael respond.

**Mr Perley:** Yes, that's part of what I was going to say. First of all, we talk about this substance as a legal product, and yes, it is a legal product. It is an anomaly. It is unique. There's no other product in the retail marketplace I know of that kills when used as intended. I have a sense that this is going to entrench if we're not careful about this issue, that the "legal product" designation is going to keep being repeated.

Rather than saying, "Well, wait a minute; yes, it's legal," if it were now proposed for use in the marketplace, it would not be allowed into the marketplace. So while we have its designation as officially legal at the moment, we all know about its effects. We all know that it has no redeeming value, and we have to treat it as an

anomaly. I think that becomes even more important in the context of retailers and business people who have at the same time—they engage in retail activity, of course, but they have an ethical responsibility, a code of conduct, they're regulated under the Health Disciplines Act. I believe the code of conduct of the Ontario college reads in part, "Pharmacists should never knowingly condone the dispensing, promoting or distributing of drugs"—and nicotine and the materials in these cigarettes are certainly drugs, particularly nicotine—"which lack therapeutic value for the patient."

It seems to me that if there's a substance on the market which more lacks therapeutic "value" for the "patient," I don't know what it is other than cigarettes, and particularly nicotine. So I think we have to look at this situation as an anomaly. Again, we can keep saying, "Yes, it's a legal product." Why are we here regulating this product if it's just another legal product? So we have problems with this that I've described and I think we have to look at the product in that context.

**Mrs Karen Haslam (Perth):** I wanted to touch briefly on the possibility of bringing in a tobacco control board—because you mentioned it; it was raised yesterday—and whether that would be a long-term goal of the health community to put it into a situation where it was very similar to the Liquor Control Board of Ontario. I wondered if you see that helping us achieve our policy in this area or whether we're looking at this legislation as a first step. Spitting tobacco was the other one; you said, "Ban it now." Would you look at this legislation as being the first step and coming back to some of these problems in the future over the long term or would you recommend: You've got it here; do it all now?

**Mr Ronson:** Certainly, on spitting tobacco, our recommendation would be to do it now. The problem can be dealt with now. It hasn't, as Michael mentioned, become an epidemic. It risked becoming one as a result of role models or lack of role models like Pat Borders, who must be one of the most notorious for those of us who watch Blue Jays games.

On the question of the tobacco control board, Mrs Haslam, we do not support that, certainly at this stage. Whether we would at some future stage, I think, is hypothetical. However, as Michael mentioned, the sister agency of the liquor control board, the Liquor Licence Board of Ontario—we would support the use of the liquor licence board mechanism to license retailers of tobacco products. Indeed, we've had preliminary discussions with the liquor licence board, and its legislation would allow it to take on the licensing function for additional products.

**The Chair:** I'm sorry. We're going to have to end our questioning there, but I want to thank you for your submission. As you indicated, there may be other material you want to bring to the committee's attention. Please do so. I suspect that you will be close to the hearings as we go along in any event.

**Mr Perley:** I have just one item quickly, a brochure we've prepared stating the full case in support of the pharmacy ban. I'll provide that to the clerk for distribution to the committee.

#### CANADIAN ASSOCIATION OF CHAIN DRUG STORES

**The Chair:** If I could then call upon the representatives from the Canadian Association of Chain Drug Stores. If you would be good enough to come forward. Welcome to the committee. Once you've had a chance to get settled, if you would introduce yourselves for the committee members as well as for the television camera. You have half an hour for the presentation.

**Mr Jim Waters:** Good morning, Mr Chairman, honourable members. On behalf of the Canadian Association of Chain Drug Stores, I would like to thank you for the opportunity to appear before you today and to share our views on Bill 119. My name is Jim Waters. I'm executive vice-president with Canada Safeway. We are a member of the Canadian Association of Chain Drug Stores. We also operate pharmacies in northwestern Ontario.

The Canadian Association of Chain Drug Stores was established in 1989 as a national industry association of small, medium and large drugstore chains. Our members represent almost 50% of the community pharmacies in Canada and one third of Canada's pharmacists. Together we fill almost 60% of all prescriptions in Canada.

As a national association, we are naturally concerned with provincial legislation which may have ramifications in other jurisdictions. We are here then to voice our concern over paragraph 4(2)8 of Bill 119 and to present to you some new research that bears directly upon this bill.

With me today are Rod Stamler and Mario Possamai of Lindquist, Avey, Macdonald, Baskerville. In preparing to appear here, we asked ourselves what the most useful information was that could be offered to this committee. We came to the conclusion that a definitive study on the contraband tobacco market and the impact Bill 119 would have on it would be a valuable addition to the information base on which the committee and the government will make their decisions ultimately. To gather that information, our association approached Lindquist, Avey.

Lindquist, Avey is Canada's leading forensic accounting firm. The firm's reputation was established in its work on money laundering and the drug trade in Canada and around the world. In recent years the firm has become the recognized expert on the contraband tobacco market in this country.

The study you will hear today will present to you evidence that the pharmacy tobacco sales ban does not represent a public policy gain, nor a gain for public health. We support the intent of the bill, but the study demonstrates what we all know, that banning the sale of tobacco in drugstores won't lead to one less cigarette being smoked.

I would like now to introduce you to Mr Rod Stamler, a principal and corporate investigator with Lindquist, Avey. Rod is an internationally recognized expert on the illegal drug trade and the underground economy as a whole. He will explain to the committee the results of his study and then show a brief videotape produced in conjunction with his research. We will then be delighted to hear any questions.



**Mr Rod Stamler:** As Jim Waters stated, I am a principal at the firm of Lindquist, Avey, Macdonald, Baskerville. We are a firm of forensic and investigative accountants and we have been investigating the contraband tobacco trade since 1990.

For 33 years I was a member of the RCMP, retiring in 1989 as assistant commissioner. In the 1980s I headed the RCMP's effort to control another illegal market; namely, illegal drugs. For a number of years I worked at the United Nations on international drug money laundering and strategies. I mention this because the problem of dealing with drug traffickers is not unlike that of trying to control the contraband tobacco market. We have just completed a comprehensive investigation of the contraband market in Ontario. This morning I want to present our findings. I want to explain why, in our view, banning tobacco sales in pharmacies will contribute to the contraband problem and why it will not reduce tobacco consumption, especially among the young people.

Let me begin by introducing a video documentary we have prepared. It summarizes our report and outlines some of the implications of Bill 119's proposed ban on tobacco sales in pharmacies. Could I ask that the video be turned on?

*Video presentation.*

1049

**Mr Stamler:** As you saw in the video, if you go to the Cornwall area on any given night, you will find snowmobile after snowmobile ferrying contraband cigarettes into Ontario. Police estimate that 50,000 cartons of contraband cigarettes are moved across the St Lawrence each day and they can only seize a tiny portion of that amount.

Our research indicates that Ontario consumers will easily buy illegal cigarettes from a variety of outlets. Some commonly found typical purveyors are independent corner store operators, bars, restaurants and other similar outlets. People are also selling out of their homes, their basements, their garages. As a matter of fact, this morning I spoke to one of my colleagues and he said, "I was coming through the underground system from the subway into our building and there was a man sitting there with cartons of tobacco, selling them to passersby." That was this morning, underground in downtown Toronto.

The plain fact that retailers of contraband cigarettes face little risk that their dual inventories will be detected by law enforcement spurs them on in this particular market. Even if they are detected, enforcement does not seem to be a deterrent.

For contrast, let us look at 1,400 drugstores currently selling tobacco in Ontario. They do so in an atmosphere of tight regulations and exacting internal policies and procedures. Pharmacies are less likely than other retailers to hold dual inventories of both illegal and legal tobacco products. The incidence of pharmacies being implicated in contraband sales is extremely rare. In addition, pharmacies maintain and promote strict standards with respect to prohibiting tobacco sales to underage customers.

Let me also draw your attention to a key point in the video: Young smokers have no trouble getting contraband

cigarettes from a variety of outlets, but not from pharmacies. This is demonstrated in the dramatized sequence between the clerk and the underage person you just saw.

As indicated in the video, we estimate that in 1993, more than one in four cigarettes consumed in Ontario was contraband. We conservatively estimate that by 1999, if there is no change in federal-provincial taxes or in any other factors which may affect the contraband market, nearly half the cigarettes consumed in Ontario will be contraband.

What could change this scenario is if customers could no longer buy cigarettes in pharmacies. Let's look at what would happen. In doing so, four factors need to be kept in mind:

First, public opinion surveys indicate that consumers will go elsewhere to buy cigarettes.

Second, our research and that of others indicates that participating in the contraband market is tolerated by many residents of Ontario.

Third, research indicates that smokers are very price-sensitive. They seek out the best deal they can.

Fourth, a number of social studies have shown that if people believe that their neighbours are cheating the tax system, they'll also be inclined to do it themselves.

If consumers cannot buy cigarettes from drugstores, they will seek out alternative sources. Some, like independent corner stores, have commonly been found to be typical purveyors of contraband tobacco products, or they may learn through word of mouth that they can buy cheap cigarettes. That's the term that is used when people walk into a store, "I want the cheap cigarettes." Thus the possibility of coming into contact with the contraband market increases, and since smokers are extremely sensitive to lower prices, the likelihood will also increase that they will opt for the much cheaper contraband product.

In our view, the fewer number of legal retail outlets, the harder it will be for smokers to obtain cigarettes legally and the more likely it will be that they will participate in the contraband market.

What smokers will find on the market are these kinds of brands. I have here a package of regular duMaurier, which is manufactured in Canada, exported and smuggled back into Canada duty-free. No US tax, no Canadian tax is applied to that particular product. It sells for about \$22 a carton average.

We also have here a package which is very similar in style called DK's and a package called Commonwealth. These two are Canadian-blend tobacco products manufactured in the United States and developed and blended to Canadian standards and tastes. They sell for about \$15, \$16 and \$17 a carton.

We have here a package of Player's cigarettes, also manufactured in Canada, exported, smuggled into Canada, sold for \$22 a carton; Putter's Light, resembling Player's, \$16, \$17 a carton, \$22 a carton, manufactured in the United States, manufactured in Canada.

Another product, Export A, is \$22 a carton on the black market. Canada Goose, again manufactured in the



United States, sells for \$15 or \$16 and I believe it would drop to \$15 and \$14 a carton for these particular products if there is any change in price of the regular Canadian manufactured product.

We also have other brands, such as Raven, which is sold for \$15 a carton. It's the cheapest, if you will, of the contraband cigarettes and it's manufactured in the United States, Canadian blend. Another very popular brand is Marlboros, of course, all smuggled into Canada. They sell for between \$17 to \$22 a carton, and are manufactured in the United States, but no US tax is applied to this particular product. So it really doesn't matter what the US price is, because at the present time the contraband dealers are not paying US tax on any of these products. They're coming into Canada tax-free, period.

In our view, by banning cigarette sales in pharmacies, Bill 119 will not further the government's objective of reducing tobacco consumption. Who will benefit? Criminals are attracted to the contraband market by high profits and relatively low risks, and this is an illegal enterprise. Not surprising, our research indicates that there is involvement in the contraband sector by many organized criminals. There are indications that some tobacco smuggling networks are also handling other illegitimate products, including alcohol, arms and illicit drugs.

This suggests that crime groups are well positioned to move into other commodities and it is a worrisome development when one considers that Prohibition in the United States created groups that went on to dominate organized crime in North America for decades.

In conclusion, let me state that in our view banning tobacco sales in pharmacies will not reduce consumption in Ontario, but it will create a new opportunity for the contraband section. Our conclusion is that banning tobacco from pharmacies will contribute to the expansion of the contraband market. Thank you very much.

**Mr Jim Waters:** We'd now be pleased to answer any of your questions.

**The Chair:** Okay, thank you very much. We are under a tight time frame so I'm going to be able to permit two questions on this round. Mr Wilson and Mrs Haslam.

**Mr Ted Arnott (Wellington):** Mr Waters, you're a pharmacist.

**Mr Jim Waters:** No, I'm not.

**Mr Arnott:** Are there any pharmacists here among your numbers? Do you agree that it's ethically inconsistent for pharmacists to be selling tobacco products?

**Mr Jim Waters:** Our position on that really is that tobacco is a legal product and will continue to be in the foreseeable future. There are special interest groups out there that think retailers should not be selling disposable diapers. Some special interest groups think we should not sell contraceptives or certain products from certain countries. The truth is, as I stated, tobacco is a legal product. As long as it remains that, we feel that it's unfair to single out one class of retailer and say, "You cannot sell it," when all other retailers who wish to, can.

**Mrs Haslam:** I have so many I don't know where to begin. We receive letters, and this one is from the

Sudbury district health unit, talking about public policy being dictated by individual economic self-interest or by enlightened public health policy. In your brief, you talk about how you are stringently watching the sale of tobacco, whereas I come at it as an idea where I think the statistics prove that when you reduce the number of places selling tobacco and the availability, the young people won't be so prone to start.

On page 12 of your report from Lindquist Avey you say, "A common practice in the industry is that if an employee of a drug store sells tobacco to a minor that would be just cause for his or her dismissal." Do you have any statistics or can you tell me how many employees have been dismissed for doing this?

**Mr Stamler:** Yes, not an exact number but there have been quite a number. From the members we have contacted, there have been quite a number of those incidents, I would estimate in the range of 25 to 30 situations, where people have been either warned or disciplined or dismissed.

1100

**Mrs Haslam:** So even in a situation in your stores, there are still opportunities for young people to buy cigarettes illegally.

**Mr Stamler:** I'm sorry. Illegally?

**Mrs Haslam:** There are still opportunities for young people to have access to cigarettes.

**Mr Stamler:** Yes, but I must point out that by sending them elsewhere, that same young person goes to a convenience store that also sells contraband products. My question would be to myself—

**Mrs Haslam:** By increasing penalties within the legislation, we then may be able to address that concern at convenience stores.

**Mr Stamler:** It's my opinion that legislation will not control that kind of activity. It's my opinion that this is a consensual criminal activity in Canada and in Ontario, and I don't believe law enforcement can do much damage in terms of dealing with that kind of criminal activity.

**The Chair:** I'm sorry, but we're going to have to end there. I would just note that you have provided us with the full document of the study that you have done and members will have an opportunity to consult that as well. I thank you for coming before the committee today, for your presentation and for the video.

**Mr Jim Wilson:** Mr Chairman, I would like to seek some information from the parliamentary assistant at this point.

Ms Haslam just made a statement as a member of the government side. I'd like to see how it's backed up. She said that if you reduce the number of places that sell tobacco, statistics prove that it will decrease the number of young people smoking. When I pursued this matter with the minister, she was unable to produce any statistics or studies. I'm wondering if the parliamentary assistant can produce such statistics or studies, and I would request that of him.

**Mrs Haslam:** That's true and I would like to clarify. I meant that statistics show that when you reduce the

number of places available that sell cigarettes, the number of people who smoke are reduced. I apologize if I said young people.

**The Chair:** Okay. I think the request stands.

**Mr Jim Wilson:** Young or old.

**Mr Larry O'Connor (Durham-York):** Thank you for that question, Mr Wilson. I'm sure that as we proceed through the committee hearings, we're going to hear from people like the Addiction Research Foundation who would be better equipped to answer that question. It's been pointed out, and I'm sure we may even hear from people like the cancer society, that if you restrict the number of access points for tobacco products, then you're going to cut out some of the sources that young people are purchasing the cigarettes from, but we'll hear more of that from the Addiction Research Foundation. I'm sure you'll want to ask them that question when they appear before the committee.

CANADIAN CANCER SOCIETY,  
ONTARIO DIVISION

**The Chair:** We now have before us the representatives of the Canadian Cancer Society, Ontario division. If you would be good enough to introduce yourselves, then please go ahead with your presentation. We have half an hour.

**Dr Donald Cowan:** Mr Chair, I'll introduce the members as we proceed.

First of all, may I express our appreciation to you for allowing us to appear here today. My name is Don Cowan. I'm a physician. I've practiced oncology and cared for patients with cancer since 1963, when I finished my training. I work at Sunnybrook Health Sciences Centre and the Toronto Bayview Regional Cancer Centre. I also do administrative work for the Ontario Cancer Treatment and Research Foundation, but most importantly today I am here as a volunteer of the Canadian Cancer Society.

What I propose to do is three things: say just a few words about the cancer society, tell you why we're here and give a few facts about tobacco and cancer, and then introduce three other volunteers and ultimately a fourth volunteer, who have very important personal messages to bring to you.

First, the cancer society, as I think all are aware, is a voluntary, non-profit organization. Its mission is the eradication of cancer and the enhancement of the quality of life of people who have cancer. I think our visit here today is clearly in keeping with that mission, as you will hear. There are about 130,000 volunteers in Ontario for the cancer society and somewhat over 2.5 million who support the Canadian Cancer Society of Ontario.

Why are we here? We're here to applaud the government and all parties in your collaboration on Bill 119. We clearly support the bill. We will have some suggestions, as you will hear towards the end, that we feel might improve the legislation.

The facts about tobacco use and its deleterious effects on health, with particular reference to cancer, are probably clear to everybody around this table and I almost hesitate to reiterate them. The points are clearly laid out

on pages 3 and 4 of the submission, and perhaps I should just direct you to those pages and stress several of the points.

Tobacco is a major contributor to about 30% of all cancers, unequivocally so, including about 85% of lung cancer cases. Each year about 13,000 residents in Ontario and 38,000 in Canada die of tobacco-related causes. I'd like to stress point 6. More women now smoke than men and lung cancer is a leading cause of death among women. Lung cancer is a highly fatal form of cancer. Once the diagnosis is made, only about 12% of people survive to the 10-year mark. This compares to some 40% in other forms of cancer.

I haven't said anything about the effects of tobacco on non-cancerous lung disease and heart disease and I think people around the table again know that these are substantial. What I'd like to do is really just stress two points.

Twenty years ago, the consumption of tobacco began to decrease and now we are seeing a decrease or a levelling off of the incidence and mortality curve of cancer of the lung in men. In women, unfortunately, this is an entirely different situation. Young women are beginning to smoke and unfortunately, once addicted, smoke into adulthood. This year, the mortality from cancer of the lung is now just surpassing the mortality of cancer of the breast. It's an epidemic and it's a tragedy. People begin smoking when they're young, become addicted and of course continue to smoke.

I sat around with some colleagues a year or two ago and we discussed at the university what was the single most important thing we could do in terms of health care in our country. Of course, the discussion began as if there was some huge technological advance that we could bring to play.

Clearly, the most important single thing we could do would be to eliminate tobacco. We're practical enough to know that elimination is unlikely, but this legislation can have a major impact. It must proceed. Ladies and gentlemen, the issue is about saving lives, not protecting the income of individuals and corporations.

What I'd like to do now is I indicated I would introduce some of our volunteers and the first individual is Mr John Watson. Mr Watson began using tobacco when he was about 12, he tells me. He was diagnosed with cancer of the tongue and throat cancer four years ago, he's had surgery, he's had chemotherapy, he's had radiation and he continues to battle cancer. I introduce Mr Watson who will tell you his story.

1110

**Mr John Watson:** I would preface my remarks by saying that the treatment of my tobacco-induced cancer has left me with a considerable speech impediment. I will not be the least bit embarrassed if anyone should wish me to repeat what I say. I'm most appreciative of this opportunity and I thank you, ladies and gentlemen, for allowing me to be here.

I started to smoke when I was about 12 years old. My father was a very heavy smoker and I tried to liberate the odd cigarette from him. I wasn't terribly interested in



smoking, but I'm a very determined person, so I stayed with it until it had a hold on me. I had no trouble buying cigarettes. I'm 71 years old. When I was 12, I could buy cigarettes anywhere in Toronto, a package of five cigarettes for five cents; 10 cigarettes for 10; 25 and so on. It was no problem.

At 15 years of age, I ran away to sea. As an ordinary seaman, peer pressure took care of my smoking from then on. I was a very young person in the company of hardened sailors who all smoked a pipe, and if I was trying to be a man among men then pipe smoking was going to be my choice.

I became a very heavy pipe smoker. I was in the merchant marine, where we worked a minimum 84-hour week, so I smoked a minimum of 84 hours the hardest plug tobacco that you could find. It was part of my pay.

My wife is a nurse, my daughter is a nurse married to my oncologist, my sister is a nurse married to a radiologist, so I had certainly plenty of advice about smoking. But I had lost seven ships during the war—I didn't lose them; I know where they are—and I was the sole survivor from two of those ships, so I knew that cancer wasn't going to get me.

I appreciated the advice I was getting from my family, but five years ago it got me. I was diagnosed as having squamous cell carcinoma of the oral pharynx, which manifested itself in a massive tumour at the base of my tongue, so massive that when I shaved in the morning, each morning I could see this thing getting bigger.

I underwent seven weeks of simultaneous chemotherapy and radiation, the chemotherapy being cis-platinum, which is very, very strong. I would go in the morning, have my three hours of chemotherapy, nip across the hall for my four million volts of radiation, and hurry back to my daughter's place to throw up for eight or nine hours, so I could be ready to go again the next day.

My weight dropped from 184 pounds to 129 pounds in seven weeks, but at the end of seven weeks I was ready for surgery. The surgery involved cutting my jaw in half and removing the right-hand side, then removing a large portion of my tongue and fastening a new tongue from the muscle in my right forearm and part of my right thigh. I think it's the piece from my leg that makes me run off at the mouth sometimes.

I admire tremendously the task that you ladies and gentlemen have tackled. I don't want anybody ever to have to go through what I have been through. I know that the cessation of the sale of tobacco entirely would be the answer and I also know that can't happen; it never will happen. But we must, with your help, eliminate the ease of purchase of tobacco that young people have today. I am confident in my mind that if we can keep them away from that tobacco until they are really old enough to think about it, they won't do it because the need won't be there, and because nobody is doing it, there will be no peer pressure.

That's my story. I thank you very much for your time and generosity.

**Dr Cowan:** The next individual I would like to introduce is Ms Mabel Fraser. Ms Fraser is the widow of

Paul Fraser, who died last fall, some nine months after having had the diagnosis of cancer of the lung made. He was 55 years of age. He'd been a heavy smoker most of his life, having started at age 12. Ms Fraser will tell us more about this.

**Mrs Mabel Fraser:** I would like to take this opportunity to thank you for the opportunity to speak to you today. My husband died October 28 last year from lung cancer after having smoked upwards of three packs of cigarettes a day for most of his adult life. In his 55 years, he accomplished much and had great success with all he attempted and was much respected and loved by his peers and family. One battle in life he lost; one thing he could not do, regardless of his many valiant efforts, was to stop smoking.

He started smoking as a child. Who knows why? Desire to be cool or to fit in is rampant among our youth, but what if the means were unavailable? What if the desire to fit in and conform were coupled with difficulty? Perhaps then the end would not be as likely.

A vending machine, for example, provides instant and easy access to even the youngest child. All the laws in the world against selling cigarettes to minors are useless if they have easy access to an impartial machine. At least with human intervention we stand a chance of keeping some children from beginning this horrible addiction. Perhaps in time we can save a few of them from suffering the slow deterioration of body and mind that will almost inevitably kill them before their time, as it did my husband.

The addictiveness of smoking is so strong. He tried several times to quit, using all the toys currently available, from hypnotism to gum, but it was all futile. His habit controlled him completely until the end. After lung cancer killed his father, who was also a lifelong smoker, he said to me then, "I will probably die the same way," but still could not quit. His brothers, two sisters and son-in-law continue to smoke today, even after being devastated by his death.

The human impulse to believe that they are immune to certain things, the "It won't happen to me" syndrome, is especially strong when combined with a severely addictive drug.

#### 1120

To have cigarettes available in pharmacies must make already sceptical teens laugh. We tell them how bad cigarettes are for them and how smoking may kill them, and then make them available alongside the baby formulas, the toothpaste, the aspirin and the vitamins in pharmacies.

Before he got cancer, my husband said he wished he had never started smoking and hoped his grandchildren, nieces and nephews would never start. Making access to cigarettes harder would be a good place to begin.

In conclusion, my husband finally quit smoking four days before he died, only because his cancer had spread from the lung to the brain and he no longer knew he wanted a cigarette.

Thanks so much for your attention.

**Dr Cowan:** I'd next like to introduce Miss Kelly



Fairchild, who is 15 years old, a high school student, and who told me that at great personal sacrifice she's missing school this morning to be at this hearing. She doesn't smoke but many of her friends do. She will, among other things, tell us how easy it is to buy cigarettes and perhaps something about the effects that advertising has on young people.

**Miss Kelly Fairchild:** Thank you for this opportunity to speak to you. I believe that this legislation is important, as do many of my friends. I am 15 years old and some of my friends who smoke are 13 and 14. They all started smoking because of peer pressure, yet none of them ever talk about quitting.

I've seen kids smoking almost everywhere: at bus stops, in schools and in restaurants. They don't seem to care about their future health; they only seem to care about what they think looks cool. I don't smoke because I think it's a disgusting habit. Most teenagers care a lot about their appearance. That's why I don't understand why some of them smoke. It turns your fingers and nails yellow, stains your teeth and gives you bad breath, but they still think it makes them look cool.

My mother and my sister, who is underage, both smoke, and at times I find difficult to be around them. It used to be okay with just my mom smoking, but lately, with my sister smoking too, my asthma has been getting worse. I used to buy cigarettes for my mom until I became aware of how dangerous they are, so now I refuse to buy them for her.

I took part in a compliance check last fall. It was then I realized how easy it is for someone under 15 to purchase cigarettes. I believe the legislation should make it impossible for kids to buy cigarettes, especially a single cigarette. Selling singles makes it too convenient and too affordable for kids. I also believe the cigarette manufacturers should not be allowed to advertise cigarettes in teen magazines because it gives teens the impression that it's cool and mature for them to smoke.

Another aspect of selling cigarettes that I think is stupid is that a pharmacy dispenses medicine for the benefit of your health and then it will sell you cigarettes which will eventually kill you. As this legislation stops the sale of cigarettes to kids, I believe there will be less smokers and less cancer victims in the future.

**Dr Cowan:** The last individual I'd like to introduce is Ms Ruth Lewkowicz, who is a volunteer and chair of the public issues committee of the Ontario division.

**Ms Ruth Lewkowicz:** Our previous speakers have spoken about the harsh human reality that comes with tobacco use. I'm personally, even though I know their stories, overcome. But my role here today is talk about the legislation, what's good about it and what must be done to make it even better. I'd like to do that by considering the three primary objectives of the legislation separately.

The first objective of Bill 119 is to restrict the sale and use of tobacco products by young people and by others. Access to tobacco products can be significantly reduced by making sure the ban on vending machines remains intact. As we all know from Kelly's presentation and

even from our own experience, kids can be very resourceful, and if their access to cigarettes has been cut off through retail outlets, then they will seek out other sources. We cannot let them get their cigarettes from vending machines. That ban must remain intact.

The legislation must also prohibit the sale of kiddie packs. Those are small packs of less than 20 cigarettes that are sold at lower prices. Teens, as research indicates, are very price-sensitive when it comes to cigarettes and kiddie packs are an attractive purchase choice for them. Kiddie packs are already banned in Nova Scotia and British Columbia. We now have the opportunity to do that in Ontario.

The second purpose of the legislation is to reinforce the hazardous and addictive nature of tobacco. The legislation must ensure that the sale of tobacco products in pharmacies is prohibited. Pharmacists cannot continue to dispense lifesaving medications at the back of the shop while selling a lethal and addictive product at the front of the shop. By banning tobacco sales in pharmacies, you are making a clear statement that this is an addictive and deadly product.

While we're on the topic of pharmacies, the legislation must clearly define the term "pharmacy" so that tobacco products are not sold in any area directly or indirectly associated with the sale of health products. The integrity of the legislation cannot be undermined because the stipulations about physical setup, allocation of space and the placement of products are open to interpretation. These definitions must be airtight.

The legislation must also take an aggressive stand on packaging and health warnings. In addition to the strong stand on health warnings and signage, the legislation should mandate the use of plain packages. I have here for your viewing an example of a plain package: a buff background, brand name in a standard typeface. You will note the very prominence of the health warning. Compare that to your average brand pack. I challenge you to find where the warning is on this. I'd be happy to circulate them for you to look at.

The Canadian Cancer Society recently funded research that found that plain packages are more likely to deter children from starting to smoke. The very appearance of the plain package conveys the seriousness of the activity and makes the health warnings more prominent. The research also found that the imagery associated with tobacco products, that it's such a turn-on and so appealing and attractive to teens, is equally a turn-off when they see a plain package.

The third objective of the legislation is to ensure compliance with the law. The law, any law, is only as good as the enforcement. Bill 119 approaches enforcement through statutory prohibition. The Canadian Cancer Society does not believe that's an effective approach. What this means is that the resources to enforce the act through the public's tax dollars will likely come at the expense of enforcement in some other area. This will result in a constant juggling act to determine priorities. Where do you think police officers will place their efforts, in stopping street crime or in policing retailers?

The only effective enforcement approach is through a

self-funding licensing system. A recent study in the United States found that sales rates to minors decreased from 70% to less than 5% in 18 months after the imposition of a retail licensing system. This study also found that smoking rates among adolescents were reduced by more than 50%. That, ladies and gentlemen, is what we're all about here today.

In conclusion, the committee faces a critical task that has enormous implications for the health of Ontario residents. I hope that the recommendations provided in the Canadian Cancer Society brief and highlighted here today will help the government make a major legislative step towards eliminating tobacco-related disease in our province. With this legislation and the proposed amendments, the government can feel confident that it will reach its tobacco reduction targets.

On a final note, the Canadian Cancer Society would like to praise the Minister of Health, Ruth Grier, and the Minister of Finance, Floyd Laughren, for their opposition to the reduction of tobacco taxes. We commend them for their strong commitment and leadership on this matter. None of what we are here talking about today means anything if the taxes on tobacco are lowered, because this action will only serve to put more cigarettes in the hands of more children. This government, any government, cannot and should not compete on the basis of price with smugglers.

Bill 119 should be the most effective law in the country. It should be proclaimed as soon as possible and the penalties should be the strongest of anywhere in the world.

1130

**The Chair:** I apologize; we're tight for time, if members could keep their questions succinct.

**Mr McGuinty:** Thank you very much, all of you, for a very compelling presentation. Mr Watson, I for one would be very interested in reading your memoirs about your time in the navy and I hope to see that shortly. Mrs Fraser, I know it was difficult for you, but rest assured that your message has not gone unheard.

Kelly, I want to focus in on you. The primary purpose of this legislation is to make it harder for kids to start smoking. One of the things that it proposes to do is to ban sales outright in pharmacies. I want to know, when you think of your friends who smoke or your sister, how will this ban in pharmacies affect those kids? Will they stop smoking? Will they look elsewhere?

**Miss Fairchild:** It's more convenient in pharmacies but they probably will look elsewhere. Some of them will probably stop if it's more inconvenient in pharmacies.

**Mr Jim Wilson:** I too want to thank you on behalf of our caucus for a compelling presentation. On page 7 of your written submission, the last line of the second paragraph that deals with section 9 is a very disturbing sentence. It says, "As the legislation is now written, it would appear to permit the use of tobacco products on the grounds of each of the places cited; in the case of schools and day nurseries, it would permit children and adult role models to consume tobacco products on the property."

I want you to expand on that because certainly the intent of the legislation is to ensure that people can't smoke in day nurseries or on school property.

**Ms Lewkowicz:** What we're trying to ensure here is that this possibility doesn't exist, that the definitions in the legislation are clear and precise in terms that we're talking inside the building as well as on the grounds.

Right now, in my work, I have the opportunity to go into a school from time to time and I'm appalled by the number of teens Kelly's age and even younger who are loitering around the doorways smoking. We know that in certain day care centres, when the staff are not permitted to smoke in the presence of children, they will just go outside the main entrance and smoke. So what we want to do is eliminate the presence of tobacco from anywhere near where there are children. That's inside and outside.

**Mr Paul Wessinger (Simcoe Centre):** Thank you very much for your presentation. You certainly impressed us with the need to have the most effective legislation we can in this area. I'm just going to focus in on one area and that is your recommendation with respect to banning smoking in public places. I think this is very important obviously, first of all because of the second-hand smoke aspect, and secondly the more places people cannot smoke, I would suggest that perhaps it has an impact on reducing the smoking level.

What I'd like to know is specifically how you would define what public places where you would prohibit smoking, what you mean by "public places." Do you mean interior spaces, or in some cases you obviously mean interior and exterior, as in the day care situation, and also do we mean by "public places" places the public has access to or do you mean "public" in the sense of municipal property, provincial property, school board property? I wonder if you could elaborate.

**Ms Lewkowicz:** Go on; that sounds very good.

**Mr Wessinger:** I'd like to know. I'm looking for something more concrete because I will be quite frank with you: I would like to strengthen this section in the act and I'd like something specific.

**Mr Drummond White (Durham Centre):** Don't give up.

**Ms Lewkowicz:** Thank you very much, Mr White. I think what we're after here is that we'd like to define all public places as areas where the public has the opportunity to congregate, both indoor and outdoor. For example, it's not good enough to ban smoking in covered arenas; we also want to prohibit smoking in open-air arenas, places where even though there is fresh air around, the sidestream smoke will affect people sitting next to you or behind the smoker. I think we have to be as all-inclusive as we possibly can.

**Mr Wessinger:** Thank you very much. I appreciate that.

**The Chair:** On behalf of the committee, in particular to Mr Watson and Ms Fraser, we know it is not always easy to relate personal experience and we really appreciate the fact that you were part of the delegation today and shared that with us. I'm just sorry that time has run out. Thank you for coming today and for your presentation.



## ONTARIO PUBLIC HEALTH ASSOCIATION

**The Chair:** I call upon the representatives of the Ontario Public Health Association, if they would come forward, please. Welcome to the committee. Once you're settled, please introduce yourselves and go ahead. We'll just let people move out of the room so you will have our undivided attention.

I think some peace has returned, if you would please go ahead with your presentation.

**Ms Jane Underwood:** My name is Jane Underwood. I'm the president of the Ontario Public Health Association. Anne Lessio is a volunteer member of our organization, and Peter Elson is the executive director of the Ontario Public Health Association.

We are a 3,000-member charitable organization that works to strengthen the impact of people who are active in community and public health throughout Ontario. Our members are drawn from every community health discipline and location within the province, from Windsor to Thunder Bay. They include people from community health centres, public health units, universities and community agencies.

The Ontario Public Health Association is no stranger to tobacco legislation. It was OPHA that called on the Minister of Health to develop a comprehensive tobacco strategy for Ontario. It was our organization that called for effective protection of workers from environmental tobacco smoke. It is public health workers who most often propose and enforce municipal smoking bylaws. OPHA comes to you today to add our voice to the others who see tobacco for what it really is, the leading cause of preventable death in Ontario.

The Ontario Public Health Association strongly supports the introduction of legislation which will restrict access to young people and will protect non-users from environmental tobacco smoke. Enforced legislation is crucial in the overall strategy against tobacco industry products, as is public education and societal support for healthy children.

We want to express our appreciation to the government for taking a leadership role in the tobacco fight by introducing Bill 119. We also want to take this opportunity to acknowledge the support of the opposition parties in making tobacco use a non-partisan matter and supporting the bill throughout the legislative procedure.

**1140**

Bill 119 aims to prevent the provision of tobacco to young persons and to regulate its sale and use by others. OPHA strongly supports this intent. There are, however, a few comments we would like to make for your consideration.

OPHA commends the government for the provisions in Bill 119 that restrict access by raising the legal age of purchase to 19 and requiring proof of age as important steps to achieving the goal. The onus must be on tobacco retailers to operate legally. Research has indicated that these measures prove very effective in reducing youth access to tobacco industry products.

Minors have little difficulty in purchasing tobacco, as you've already heard this morning. OPHA and others

have conducted surveys in stores in Toronto, and in 92% to 95% of cases, young people, some as young as 12 or 14, could have purchased cigarettes without question.

According to the 1991 Statistics Canada General Social Survey, 16% of teenagers between the ages of 15 and 19 are daily smokers. It is estimated that Canadians under the age of 19 consume over two billion cigarettes per year, representing an annual market of over \$400 million for the tobacco industry. We are putting a higher price on the value of tobacco profits than we are on the lives of our young people. OPHA is here to tell you that our members value the lives of our young people as the single most valuable resource any society will ever have.

**Mr Peter Elson:** Recent research indicates that three elements are key in legislation to prevent tobacco sales to minors: vendor licensing, active compliance and penalties. This study showed that temporary suspension of a licence had a greater impact than a monetary fine, because so much of the store's profit was made through cigarette sales.

Studies in two US communities found a direct link between enforced restrictions on sales to minors and reductions in youth smoking. Youth smoking rates plunged by 30% to 70% in those two communities, showing that tobacco-access laws do accomplish their objective, especially when they are enforced.

Therefore, OPHA recommends the implementation of a self-financing licensing system for tobacco retailers and establishing an enforcement system, complete with a schedule of penalties, including a licence suspension and monetary fines.

OPHA is particularly pleased with the provision of Bill 119 which prohibits the sale of tobacco industry products in all health care facilities, including pharmacies and any retail establishment that houses a pharmacy.

It is crucial to establish tobacco industry products as the health hazard they are: lethal when used as directed. These products cannot be associated with health facilities nor licensed health professionals. The major benefit of the termination of cigarette sales in pharmacies is the elimination of conflicting messages about the risks of tobacco products being sent to people of all ages, but especially to the young.

The Ontario College of Pharmacists asked the province for legislation to ban the sale of tobacco industry products in pharmacies in June 1991 when it was apparent that many large drugstore chains would not cooperate with a voluntary sales ban being advocated by the college. The pharmacies in this province have been aware of the college's request and have had ample time to prepare for terminating their tobacco sales. Therefore, OPHA strongly recommends that the pharmacy ban become effective 90 days after the legislation comes into force.

We're also pleased to see that Bill 119 requires that signs displaying health warnings and other pertinent information be posted at all retail locations. We urge the committee to recommend that plain packaging requirements and strong health warnings information be mandated under the packaging regulations. OPHA strongly



supports the banning of cigarette vending machines. As you heard earlier in the other testimony, they represent a means of uncontrolled access to this addictive and lethal product.

**Ms Underwood:** OPHA supports Bill 119 in the prohibition of smoking-designated public places, including schools, day cares, retail establishments and others. However, we see opportunities to improve in the protection against the health hazards of environmental tobacco smoke.

Environmental tobacco smoke is classified as a group A carcinogen by the US Environmental Protection Agency. This places environmental tobacco smoke in the same category as the most deadly known human carcinogens such as arsenic, asbestos and benzene. There is no safe level of exposure to environmental tobacco smoke.

The US Environmental Protection Agency and other authorities recommend two, and only two, solutions to the environmental tobacco smoke problem: Either smoking must be prohibited in indoor environments, or if smoking is permitted, it must be confined to enclosed areas under negative pressure, separately ventilated and exhausted directly to the out of doors.

The current provisions of Bill 119 leave a large number of public places where smoking is permitted, such as entertainment facilities, sports and recreation facilities, restaurants and bars and bingo halls. Environmental tobacco smoke will continue to be a serious public health problem.

We strongly support the government's target to increase to 100% the proportion of schools, workplaces and public places that are smoke-free by 1995.

In order to reach this goal, the Ontario Public Health Association strongly recommends that the public places included in the legislation be broadened to include all public places and that a total smoking ban be imposed. A strong and consistent message about the health risks of smoking and environmental tobacco smoke needs to be sent to the public.

The Ontario Public Health Association recommends that this section be revised to include the principle of reverse onus. Reverse onus would prohibit smoking in all public places except where permitted by regulation, thus reversing the onus to defining the places where smoking would be allowed by exception rather than legislating all non-smoking areas. The reverse onus principle establishes non-smoking as the legislative and social norm. Only areas where smoking is permitted will need to be signed. All other areas will automatically be recognized as smoke-free.

We also recommend the province strengthen the Smoking in the Workplace Act to effectively eliminate exposure to environmental tobacco smoke in the workplace by either establishing a total ban on smoking or by legislating designated smoking areas which are under negative pressure and separately ventilated to the out of doors. This provision will protect all non-smoking employees throughout the province from exposure to environmental tobacco smoke.

Penalties for breaking the law need to be deterrents in themselves. We are pleased to support the schedule of monetary fines.

To date the means of enforcement has not been outlined. Enforcement is a critical piece of the legislation. If the laws are not enforced, they will be ignored. We await the province's strategy for proper enforcement of this precedent-setting piece of legislation.

OPHA views Bill 119 as a progressive step forward in the enhancement of public health. Its passing will reflect our desire to provide our young people with the support they need to say no to addiction and no to premature death.

In summary, our recommendations are:

The implementation of a self-financing licensing system for tobacco retailers and establishing an enforcement system complete with a schedule of penalties, including a licence suspension and monetary fines.

We recommend that the pharmacy ban become effective 90 days after the legislation comes into force.

The Ontario Public Health Association recommends that public places included in the legislation be broadened to include all public places and that a total smoking ban be imposed.

Our association recommends that the government strengthen the Smoking in the Workplace Act to effectively eliminate exposure to environmental tobacco smoke in the workplace by either establishing a total ban on smoking or by legislating designated smoking areas which are under negative pressure and separately ventilated.

#### 1150

**Mr Arnott:** Thank you very much for your presentation. You've said you support the bill in principle, and with your recommendations you're suggesting to the government it go far farther than it has with this bill. "To include all public places and a total smoking ban to be imposed" is what you've suggested to them, which in my view goes considerably farther than what they've suggested.

My concern with one part of the bill is that it doesn't specify absolutely the number of places at the present time where smoking will be banned. In section 9, there's a clause right at the end that says "or a prescribed place," which doesn't give us a full understanding of what the government's thinking is in terms of which areas it wants to ban at the present time versus what it might do in the future. We've expressed the concern that we should know where the government's going on this, that in terms of legislation, it's better to have these additional prescribed places discussed in the House, as opposed to having it done by regulation by the government behind closed doors.

Would you agree with that concern, that those places should be spelled out, out in the open, up front, so that everybody knows about it?

**Mr Elson:** Part of your question, obviously, is for the government. The other part is that what we're saying is that the debate should not revolve around where smoking should not take place, but where it should take place,

where in fact the government would be prepared to allow people to be exposed to environmental smoke. We are saying there shouldn't be a place in the province where anyone is exposed to environmental tobacco smoke, and others would say that the debate should be around where it is permitted for this health hazard to occur, as opposed to where it should not occur. It reflects to our recommendation about the reverse onus, that the discussion should be on the other part of the ledger.

**Mr Arnott:** Your suggestion is, though, that smoking be prohibited outside of, I assume, people's private residences and perhaps their cars.

**Mr Elson:** Yes.

**Ms Underwood:** Yes, we're talking about all public places.

**Mr O'Connor:** Thank you for your presentation and brief. The question I have for you would be on the licensing. What do you think could be accomplished that can't be accomplished through the legislation by going into a licensing system and creating another bureaucracy? Maybe you can point out some areas that you think can't be accomplished presently within the realm of the current bill. You pointed out that you think there should be licensing. Why would you like to go to licensing? What would you hope to achieve through licensing that can't be achieved through the present bill?

**Mr Elson:** I'm not sure what exactly is the point of the questions.

**Mr O'Connor:** Okay. In the summary of your recommendations, your first recommendation was "a self-financing licensing system for tobacco retailers and establishing an enforcement system complete with a schedule of penalties...licence suspension," which sounds like the ban, "and monetary fines." I just wondered what would be accomplished by going to a licensing system that can't be accomplished through the legislation that we have before us.

**Mr Elson:** My response to that is with respect to the actual financing of the enforcement aspect of the legislation. In many cases at the municipal level there are limited resources to enforce this, through public health inspection or otherwise, so that's why we're calling for the people who are in the business of making the profits, the retailers and others, to contribute to the self-financing aspect of that system.

Simply having the legislation or the licensing system in place—now, for example, it is against the law to sell tobacco products to minors who are younger than 18, and yet there are very limited means at this point financially to enforce that system on any kind of systematic basis.

Research has shown that when there is a provision for it to be enforced, there is a dramatic impact. The system needs to be self-financing, and that's why the licensing would provide the means for that financing, for the self-payment of that licensing system.

**Mr McGuinty:** Thank you very much for your presentation. I'm sure that you are not without some sympathy for people who are in the grip of the powerful addiction of cigarettes.

You want to ban smoking in all public places, save and

except those which are listed as exceptions. We've just heard from the presenters before us. I'm sure that Mrs Fraser loved her husband very, very much, and that when he was alive maybe they would like to go out to a restaurant, maybe they'd like to go out and play some bingo. This man was smoking three packs a day. He would feel a tremendous urge, his body would crave a nicotine fix.

Our government has profited from cigarette smoking over the years. We've built up industries around it. We've employed people. What do we do with these people? They can't go out of their homes now to smoke?

**Ms Underwood:** I guess there's a way of turning that question around. I agree it's a very, very difficult situation. He also was putting her at risk every time they went out.

**Mr McGuinty:** She consented to that.

**Ms Underwood:** He was consenting too, wasn't he? It's a difficult choice to make. I'm not sure that she really did have that much freedom. As you say, she loves him very much.

**Mr McGuinty:** The point I'm simply trying to make is that we get into difficulties when we stop focusing on making it harder for kids to start, when we go and focus on those who are already hooked on a highly addictive legal product. It's not easy.

**Mr Elson:** That certainly too is one of the reasons why OPHA, at the very outset, called on the government at the time to look at tobacco in a comprehensive fashion. When it comes to alcohol addiction, we do not leave people who are addicted to that substance abandoned, and neither should we as far as tobacco is concerned. If we recognize it, then the programs to support people who are addicted and who choose not to smoke need to be in place and accessible in a way that, if they make the choice, in fact they are.

Although we're talking about the particular circumstance of what was presented earlier, in fact young people too are particularly vulnerable in that regard. In many cases they cannot advocate for a change. In some cases they can, but in other cases they can't, in terms of parents who smoke, as an example.

**The Chair:** Did you want to add something?

**Ms Underwood:** I was just going to emphasize the point that the young woman made here earlier and that you heard in the earlier presentation that in day cares and schools children are exposed to seeing people smoking all the time. So we're setting a tremendous example of smoking being okay in our society today.

**The Chair:** Thank you very much for coming before the committee this morning. We appreciate it.

The committee will now stand adjourned until 2 o'clock this afternoon.

*The committee recessed from 1159 to 1403.*

**The Vice-Chair (Mr Ron Eddy):** Ladies and gentlemen, the standing committee on social development is now in session and continuing hearings on Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others.



## ONTARIO DISCOUNT DRUG ASSOCIATION

**The Vice-Chair:** The first presentation this afternoon will be by representatives of the Ontario Discount Drug Association. Please introduce yourselves and proceed with your presentation. We have one half-hour for presentation and questions at the end, if there is time.

**Mr Zel Goldstein:** My name is Zel Goldstein. I'm the CEO of Hy and Zel's. To my left is Marvyn Lubek, director of pharmacy operations for our chain. This brief was originally presented by Marvin Turk of the ODDA. Unfortunately, Mr Turk could not be here today, so we're filling in for him.

I believe that all of you have a brief in front of you that was presented by Mr Turk. If need be, I would ask Mr Lubek to read this again to you, or if not, if you want to save some time, we could just open up the floor to questions.

**The Vice-Chair:** It's as you wish, but if you would make a presentation regarding it, either in full or part, the presentation is entitled Pay Less Drug Emporium Ltd. That's across the top for members. Proceed, please.

**Mr Marvyn Lubek:** "Dear Sir:

"I am writing to you today on behalf of the ODDA (Ontario Discount Drug Association) to express the views of the members of our association toward the tobacco prevention act.

"Our association is made up of Hy and Zel, Herbies Drug Warehouse and Pay Less Drug Emporium Ltd. Between our members, we have 25 stores, approximately 75 to 100 pharmacists, full- and part-time, and between 2,500 and 3,000 employees. Our stores are all larger than 15,000 square feet and in fact average 30,000 square feet. The association stores average between 150 to 200 prescriptions per day on a seven-day week, which in fact would certainly put our stores in the top 10% dispensing stores in the province if taken as a unit.

"When the stores were originally planned and the pro formas produced, the composite involved the coming together of many departments, including a comprehensive tobacco department.

"The position of the ODDA is clear on the new proposed Tobacco Control Act. We will lose gross profit dollars which we are now applying to the professional part of the business, thus allowing our dispensing fees to be amongst the lowest in the country. As well, there will be a loss of a minimum of 100 jobs as these are the clerks and receivers that are involved with the total sell-through of tobacco products. Obviously, if the restriction of tobacco sales has the anticipated impact of decreasing our traffic flow, then we run the risk of losing many more jobs, and in fact face the spectre of bankruptcies. There are very few drugstores in Ontario today that will be able to withstand the traffic loss that is imminent if tobacco products are restricted from sale.

"Since most of the data that concerns the Tobacco Control Act is being reported by subjective surveys, the ODDA has done some of our own. Here are the results.

"From 100 customers noted purchasing tobacco from six assorted Hy and Zel and Pay Less Drug Emporium stores, 93 purchased other merchandise as well. Some-

times it was something as simple as a newspaper and/or a chocolate bar, but they did purchase something else. The average sale of the person purchasing the tobacco product plus the other goods was, including the tobacco, \$21.72. Our average sale between the two companies is in the \$16 range. Obviously then the gross profit dollars generated by these customers is significant and vital to our viability. Although it may be possible that these customers would have come into the store and purchased these items in any case, is there anyone in retail that would want to take that chance?

"Obviously, tobacco is a product that produces and encourages impulse sales.

"In another random sampling in the same six Hy and Zel and Pay Less Drug Emporium stores, we asked the customers the question (different customers from the first survey) 'Do you think tobacco products should be sold in drugstores?' To our surprise 26 out of the 100 replied that they thought tobacco products should not be sold in drugstores, 57 thought they should and 17 had no comment. It should be emphasized that none of these people had made a tobacco purchase.

"When the same question was asked again of these people but was suffixed with 'if there was a possibility that some people could lose their jobs' the sample changed rather dramatically.

"Now only 10 people of the 100 were for the tobacco sale restriction, 77 thought it was acceptable and 13 had no comment. Then we raised a third point to this question, which I believe speaks volumes on the subject. When we said, 'Do you think tobacco products should be sold in drugstores, notwithstanding the fact that there was a possibility that some people could lose their jobs and given the fact that there would be no appreciable decrease in the total amount of tobacco consumed or in the number of people smoking,' the response was startling.

"One person of the 100 suggested we should still not sell the tobacco products, 93 felt that under those circumstances we should and six people still had no comment.

"The result is incontrovertible. When people are given the choice on the one hand of a philosophical question which seems reasonable, after all it does seem on the surface inappropriate to be dispensing medication at one end of the store and a health damaging product at the other end, and the reality of lost jobs, they will invariably vote for the option that maintains jobs.

## 1410

"Integrated into the mix, of course, is the incredibility of most people when you tell them that tobacco products will still be legal for sale at convenience stores or at the gas bars or at Canadian Tire etc. At this crisis point in our economic life in Ontario, the last thing any retailer needs is further restrictions on his ability to sell a legal product. It seems if there was even a case for going to court on a restraint of trade and commerce, this would be the issue. Of course, added to the latter statement is the fact that it doesn't seem reasonable for any government to morally change the rules of the game in the middle of the game with no benefit whatsoever accruing to the public.



"It is interesting to note that Nghia Truong, who was the president of the Ontario College of Pharmacists when the college voted to ban tobacco sales, and who was in his words 'booted out over his stand on tobacco,' says, 'Somebody has to have the guts to ban tobacco rules.' I wonder if he was in a position to lose his livelihood or his job if tobacco sales were terminated in drugstores, would he express such bravado or superfluous courage. The fact that he removed tobacco from sale in his drugstore is absolutely irrelevant to the issue. Obviously tobacco was never a significant component of his profit or he never priced it competitively enough for it to become significant. It is reprehensible that someone of his reputation is conceding the loss of someone else's job. Absolutely unbelievable.

"In terms of the comments made by various pharmacists who are members of Pharmacists in Support of Bill 119, these pharmacists are speaking of a department that was never relevant in terms of the total profitability of their own stores. As well, they are speaking about their own specific situations, which obviously is totally unrelated to large stores such as those in the ODDA.

"It is true that pharmacy is my profession, but my vocation is business, and that business is the drugstore business.

"As long as I speak for over 100 pharmacists and 3,000 employees, I feel that any committee should listen very carefully to our point of view.

"It is also interesting to note that in a survey of pharmacy practice, 60% of independent pharmacists who responded said they are against tobacco sales versus just under 50% of chain pharmacists. In our survey 30% of our pharmacists also reported that they are against tobacco sales, but when it was stated that we might go out of business because of the loss of gross profit dollars and/or the ensuing traffic, only 8% were then against the sale. It is obviously a function of one's personal potential downside as to how they will decide to vote on this issue.

"In summary, it is the position of the ODDA that drugstores should continue to be allowed to sell tobacco as long as it is legal tender everywhere.

"We would also like to recommend the continuation of the province's wide advertising against smoking as it is poignant, precise and quite frightening.

"It is our belief that through increased education and communication, not arbitrary selection of sale venues, will we as a province be able to meaningfully reduce tobacco consumption and the number of smokers in this province.

"Yours truly,

"M. Turk, president and chief executive officer of Pay Less Drug Emporium Ltd and the Ontario Discount Drug Association."

**Mrs Haslam:** Do you counsel your clients to stop smoking?

**Mr Goldstein:** When the pharmacist has the opportunity to do that, if he's asked that particular question, yes, he does.

**Mrs Haslam:** Are your cigarettes sold at the front or

the back of your store?

**Mr Goldstein:** The cigarettes are sold at the front of the store.

**Mrs Haslam:** Do you know, on average, how many times you would counsel some of your patrons to not smoke?

**Mr Goldstein:** No, I couldn't quantify it or anything like that, but then again, I say that if the pharmacist himself was to be asked that particular question, he would give the answer that would be appropriate at the particular time, and that is that we are concerned about the health issue and I think that he would answer accordingly at that particular time.

**Mrs Haslam:** On page 2, you say, "given the fact that there would be no appreciable decrease in the total amount of tobacco consumed." On what study do you base that?

**Mr Goldstein:** We base it on the fact that if it's not available in the drugstores then it certainly would be available in the variety stores, the gas bars.

**Mrs Haslam:** But there would be less availability if it were not in pharmacies?

**Mr Goldstein:** No, I don't believe that would be the case. I think the tobacco consumption would be exactly the same. All you would be doing is sort of moving it around a little bit.

**Mrs Haslam:** There have been other submissions, and I maybe would just ask for a couple of comments. The Canadian Cancer Society has recommended "to reinforce the hazardous and addictive nature of tobacco products." "The legislation must ensure" that the section concerning the ban on the sale of tobacco products in pharmacies remains intact. They look at this as a health issue and that therefore, as a practitioner, as a health facility, it is giving mixed messages when you sell tobacco in the same facility. I wondered if you had a comment on that.

**Mr Goldstein:** Like I said before, we are as concerned with the health issue as anybody else is, but basically all you would be doing is diverting the problem from the drugstore into the variety store. I think the results would be the same, the consumption would be the same, but the harm done to pharmacy at that particular time would be irreparable. I think you face the option of certain pharmacies going out of business. You face the potential loss of jobs, and I don't think that really is the intent of this particular legislation.

**Mrs Haslam:** One of the other groups that came forward—and I apologize because I've been looking for it and I'm usually an organized person and can find it, but I can't—did studies that showed there wasn't an appreciable closing of businesses when pharmacies decided to not sell tobacco in their facilities.

**Mr Goldstein:** If you took some of the drugstores today, I would say that potentially the average would be 15% to 20% tobacco, total sales, in these particular stores. If you took that 15% to 20% out of there, there isn't too much left, and when you factor in the effect that these people do not come into the store any more, then you face a loss of other particular sales, as we've alluded to in this particular brief. A customer who would come

in and buy a package of cigarettes would buy something else, and if that were not available—in other words, if they would go into another store and pick their cigarettes up, they would certainly get what they needed someplace else.

**Mrs Haslam:** That would seem to contradict what the Ontario Chamber of Commerce letter says, because they said “undue economic burden on merchants who rely on the sale of tobacco products for a significant portion of their sales.” It’s my understanding that the markup on cigarettes is not a profitable business, that you’re talking about a spinoff, whereas if you replace those products like tobacco with other products, the business is still in your pharmacy.

**Mr Goldstein:** You’ll find that the consumer today really doesn’t want to go into two or three different places to obtain all their products. In other words, if they did go for their tobacco someplace else, they would look to get everything else in that particular place.

**Mrs Haslam:** I understand those concerns. My concern is health facilities, health issues, and as pharmacists you deal in—

**Mr Goldstein:** Yes, but shouldn’t a variety store be as—

**Mrs Haslam:** Well, are you a variety store or are you a health professional as a pharmacist? You are CEO and you’re looking at the business aspect and I understand that. What I’m looking at is you’re a pharmacy that has a monopoly on selling drugs. In your presentation on page 3, you talk about Canadian Tire and other facilities that do not have that ability or do not have within their facilities the pharmacist. I think the question is, as a health facility, should we be giving a mixed message that at one side you can buy products that only you sell, and at the same time you’re selling a poisonous product in your store?

**Mr Lubek:** I’d like to add that if one is so concerned about the health situation, why is tobacco legal in the first place?

**Mrs Haslam:** Would you recommend we do something stronger in the legislation?

**Mr Lubek:** If you’re not going to allow the sale of tobacco in pharmacies, then it should be illegalized in the first place.

**Mr McGuinty:** Thank you, gentlemen, for your presentation. I have difficulty conceptually divorcing one side from the other in a drugstore. I think it’s both a health care centre to some extent and a retail business. It’s a small business. I haven’t done a great deal of research on this, but I suspect that over the years governments have induced you, whether you wanted to or not, to look more to the front of the store for your returns. I don’t know whether you can operate a pharmacy profitably today solely on the basis of prescriptions, for instance.

1420

**Mr Lubek:** Not at today’s dispensing fees.

**Mr McGuinty:** Can you tell me a bit about the percentage of sales—I’m not sure if you referred to that specifically in here—in the store that are tobacco-related?

**Mr Goldstein:** I can only comment on our particular stores. The percentage of sales varies anywhere between 4% to 6%.

**Mr McGuinty:** For me, the crux of the matter here is that we all want to ensure that we can reduce overall tobacco usage. I understand there are 1,400 pharmacies in the province that sell tobacco; that’s out of 120,000 stores. That means we’re going to reduce the availability by 1%. There’ll be 119,000, whatever, stores still present in the province where somebody can buy tobacco.

I think the argument that somehow we’re going to reduce availability really doesn’t hold a great deal of water and I think the impact will be negligible. So what we’re really talking about here is the symbolism and I think most people are prepared to admit that. We’re talking about reducing the social acceptability. How do you comment on that?

**Mr Goldstein:** Are you prepared to take a gamble where you would ban tobacco sales in a drugstore and potentially have hundreds of drugstores closing up? In other words, you don’t seem to know. You don’t seem to have an idea of what impact this is going to have. I’m telling you that as a retailer—and I’ve been a retailer for 45 years of my life—in the retail business basically you try to provide everything you can for the consumer.

Tobacco has been something that has been in drugstores ever since I can remember. I remember going into a drugstore when I was 10 years old and the pharmacist himself was smoking. What I’m trying to get at here is that you just can’t zero in on the drugstore and say because you are selling a health product, you can’t sell something that is going to go against your health.

I think you’re going to redirect all the tobacco sales. The consumption will be the same and you’re not going to do away with the problem. The problem is having something that is considered to be legal, but illegal in a drugstore. That to me doesn’t seem to make any particular sense at all.

**Mr Lubek:** I would like to add that if you’d like to make this a health issue only, I think it would be more prudent to make it illegal to sell tobacco in any other store except a drugstore and allow the pharmacist to counsel on the use of tobacco. I would also do that with alcohol. Alcohol is a drug; tobacco is a drug. It should be sold in drugstores, not anywhere else. Therefore, we could counsel on the health concept.

**Mr Jim Wilson:** Thank you very much, gentlemen, for your presentation. The letter from Mr Turk, I think, goes right to the crux of the disagreement we’re having over this legislation with the government.

As you’ve heard in the questioning and in previous presenters, we’re just having a very difficult time getting the government to wrap its mind around this jobs issue. While the Premier has spent the last couple of months trying to convince the province that jobs are important, we’ve seen a number of initiatives, including this one, that could very well affect the number of people who are currently employed. It will put more of them on the unemployment lines.

I sense, though, in my dealings with this issue and my



dealings with the government that either it doesn't care about that or, secondly, it doesn't believe you. They think it's a false threat that people will lose jobs in the pharmacy sector as a result of Bill 119. Would you like to comment on that further?

**Mr Goldstein:** The government didn't believe that stores had to be open seven days a week either. With all due respect to everybody here, I don't know whether anybody really is in the position to say, "This is what's going to happen." Basically, I can tell you, with 45 years of experience in the retail business, when we were closed on Sunday we didn't do as much business as we did in the seven days.

I'm telling you today again that if you took tobacco out of drugstores, I'm not saying every drugstore would go out of business, but I'm certainly saying that a percentage of these drugstores that are currently open, providing a living for the independent pharmacist, would close up and there would be lots of people out of business. There would be families destroyed because here's a pharmacist who is making maybe \$50,000 or \$60,000 a year who could not be able to ply his trade any more. This really is not the intent of this particular law.

I think what you're trying to do is counsel the people as to what to do. I think Karen Haslam raised this point before and I believe Mr Lubek answered it quite adequately when he said, "I think pharmacy probably is in the best position to counsel." You go into a variety store, they're not going to tell you anything. If a 16-year-old went in there, they would probably sell him a package.

**Mr Jim Wilson:** Plus the clerk in the variety store isn't going to lose his pharmacy licence for breaching any of these laws.

**Mr Lubek:** I don't think the clerk in the variety store would know the effect of tobacco on the body in the first place.

**Mr Jim Wilson:** That's a good point. The law talked about morality and it's mentioned on page 3 of your presentation. For some reason, the moral high ground from the government's point of view seems to be that it's okay to take the chance that people might lose their jobs because, even though the minister admitted in the initial press conference that it was simply optics in terms of banning the sale of tobacco products—she couldn't say whether it would have any effect in terms of declining consumption by young people or anyone else—none the less, for some philosophical reason, they think it's a good idea. Is it morally right that government even take the risk to put your people out of work?

**Mr Goldstein:** Definitely not, if you're asking me. I wouldn't want to sit in judgement and potentially pass a law or have something to do with some kind of legislation that's going to put people out of business and people out of work.

**Mr Lubek:** Is it morally correct for somebody to collect taxes on something that is a health hazard?

**Mr Arnott:** That's a good question. How many pharmacies do you think a town of 2,000 could support, a small town?

**Mr Goldstein:** Two thousand people? I don't know,

I really haven't got a clue.

**Mr Arnott:** In the village of Arthur where I live there are two pharmacies for 2,000 people and about 2,000 people perhaps do their shopping in Arthur, so you may be looking at 4,000 people in total. Two pharmacies and neither one of them sells tobacco. I want to read to you a brief excerpt from an article which appeared in the *Arthur Enterprise News* last week:

"John Walsh, owner of Walsh's Pharmacy in Arthur, made his decision to get out of the tobacco business about eight years ago. Expanding his store, he replaced the display shelf and space with a display of picture frames and film. John Walsh says, 'You're contradicting yourself, trying to promote health in the back of the store and tobacco in the front.' He thinks the public is now at the point where they expect responsibility from health care services. He suspects that much of the uproar from pharmacists is due to the government's intervention in many of the other pharmacy-related issues."

To me—two pharmacies in a small town, neither one of them selling tobacco.

**Mr Goldstein:** Again, I think this is a personal decision that Mr Walsh made and probably in his particular store it turned out to be okay, but I don't think, if you look province-wide, that this thing is going to be okay. I think you're going to have some casualties along the way and I don't think this particular government that really is pro-jobs would want to have any part of any legislation that is going to put people out of work.

**Mr Lubek:** I'd also like to ask the question, do you know how many people in Arthur are not smoking because Mr Walsh hasn't been selling tobacco, or have they been able to buy it somewhere else, when they stop for gas?

**Mr Arnott:** A valid point. There are other places to buy tobacco in Arthur.

**Mr Lubek:** So if the product is available and nobody is getting counselling as to the use of tobacco, I will reiterate that the only place it should be sold is in pharmacies, where they can get proper counselling. Again, we'd also like to have alcohol, so we can counsel on its use.

**Mr O'Connor:** One brief question: In your marketing, because you're looking at this from a marketing point of view, and hearing your discussion around the counselling element, have you found then—because retail, quite a bit of it is marketing—that if pharmacists were to sell the tobacco product, you would actually increase your trade by having every person who wanted to purchase tobacco stop for that counselling? That would be a way of maybe increasing your trade. All pharmacists then have to counsel?

**Mr Lubek:** Are you recommending we do that? Because that's certainly a good marketing tool.

*Interjection.*

1430

**Mr Lubek:** Would we bring it to the back instead of having it at the front? I would certainly think that would be an acceptable situation. As far as the health situation is concerned and what we're looking at here, it would be



more appropriate than saying, "Don't sell tobacco at all," and allowing it to be sold at a gas station or at a Canadian Tire store where nobody could help the consumer.

**Mr O'Connor:** So you think it actually would make sense for the pharmacist then to spend 10 minutes counselling, which is a good idea, counselling people about the use of the tobacco, this lethal product, and as a marketing tool it would be a good tool?

**Mr Lubek:** Absolutely.

**Mr O'Connor:** Interesting. Thank you.

**The Vice-Chair:** Thank you for your presentation. We appreciate it.

#### ONTARIO MEDICAL ASSOCIATION

**The Vice-Chair:** The next presentation will be made by representatives of the Ontario Medical Association. Would the representatives please come forward, introduce yourselves and proceed with the presentation. Hopefully, there'll be time for questions at the end. We have one half-hour.

**Dr Tom Dickson:** Thank you, Mr Chairman. I'd like to introduce Dr Verna Mai, who's chairman of our section of public health, and Dr Ted Boadway, who's the director of our health policy department at the Ontario Medical Association. I'm Dr Tom Dickson, president of the Ontario Medical Association. Dr Mai will present first, then myself, and we hope to leave some time for questions.

**Dr Verna Mai:** Honourable Vice-Chair, members of the committee, I would like to thank you for the opportunity to speak on a subject of vital importance to the 22,000 members of the Ontario Medical Association. We applaud you for proposing some of the toughest anti-tobacco legislation in the world. Finally, we have a Tobacco Control Act on the legislative agenda. You are to be congratulated for bringing this act forward and for encouraging public input. Bill 119 is an excellent step towards passing comprehensive tobacco legislation.

The Ontario Medical Association has been deeply concerned about the effects of tobacco use on the population for decades. We see the effects on an individual basis every day and we know the collective costs. The evidence against tobacco use is enormous; the human toll is sickening. Yet the frustrating part is that the death and disease caused by tobacco can be prevented.

The fact that millions of people continue to smoke and thousands of children take up the habit every month in Ontario proves just how powerful and addictive tobacco is. Don't for a moment allow yourself to think that smoking is simply a bad, smelly habit. Tobacco kills 13,000 people a year in this province, and the numbers keep growing. New, still healthy converts are taking up the habit. Each month it's estimated that more than 3,000 children start smoking.

If we thought of tobacco as the poison it is, we would realize that we have a major epidemic on our hands. Sadly, still too many believe tobacco use is just a matter of personal choice. It isn't. The tobacco industry must be condemned for causing this epidemic and, as with any other major epidemic, we not only need to educate the public about the risks, but we must also not hesitate to

pass protective, tough legislation and generate a concerted public effort to combat the agent, in this case tobacco use, in our society. It won't go away on its own.

We know this government has come in for much criticism from the tobacco industry, tobacco product retailers and defenders of free speech and civil liberties. They've criticized the proposed legislation as draconian and anti-democratic. They've trotted out the old scare tactics about lost jobs and lost revenues. Sadly too, other governments seem to agree with this point of view. But what about the losses in health and life of our citizens addicted to tobacco? Don't be deterred, don't give up the fight and please don't give in.

If you will permit, a little history at this point is in order. We've been here before. There are dozens of examples of groups having opposed similar public health measures this century. The medical profession, among others, fought for the pasteurization of milk, for the chlorination and fluoridation of water, for asbestos removal from our buildings, for the vaccination of all school children in Ontario and for seatbelt legislation. Do you remember the furore over forcing people to buckle up for their safety? The list goes on and on.

These laws were also fraught with political hesitancy and heated debate, but they too were based on solid evidence. History has shown the effectiveness of enacting public policy on the basis of evidence. It's time we let everyone know that this government intends to protect the public and is dedicated to preventing yet another generation of children from becoming addicted to this lethal substance. But we do know that you need help and public support, and the Ontario Medical Association is firmly behind you.

The general public must also get involved in this battle for the hearts and the lungs of our youth. Effective health promotion requires more than just health counselling and health education. We need parents and strong role models to lead the way. We need wide public support to allow our children to grow up in a smoke-free environment. No-one should be subjected to secondhand smoke, especially children, who are most vulnerable to toxins and poisons. We need to create an environment that promotes a healthy lifestyle. We need to make it easy for people not to smoke. This keeps the environment in which children grow up consistent with the health education messages we give them in our schools.

It's an uphill battle, and we need as much help as possible to counter the tobacco industry's huge marketing machine. According to a report by the Canadian Council on Smoking and Health, people in the Ottawa-Hull area are exposed to tobacco company's sponsorship ads at least 295 million times per year. We need plain packaging to break the link between the packages and the sponsorship ads. Banning vending machines and preventing the sale of tobacco products in pharmacies would also break another major link in the tobacco industry's supply chain.

Of course, there's always more we can do as well, but this legislation is an important step in bringing our dream of a tobacco-free society a little closer to reality. Again, you're to be applauded for having the vision and the

courage to make this happen.

Now I would like to introduce Tom Dickson, our OMA president.

**Dr Dickson:** Thank you, Verna. I too wish to commend this government for enacting legislation to reduce tobacco use and, most important, to prevent children and teens from ever lighting up or chewing tobacco.

We see the tobacco industry as public health enemy number one. This might strike you as an exaggeration, but it's not, and we mean it. There is no doubt about it: Tobacco is a poison. It should be treated and marketed and displayed as a poison.

We've made significant gains over the years, and this legislation will help, but we still have a long way to go towards a smoke-free society. Since we addressed the standing committee on social development last March, 11,000 people in Ontario died from tobacco-related diseases, and 3,000 Ontario children aged 11 to 15 take up the habit each month. Tobacco use is the leading cause of preventable disease, disability and death today, so we urge this government to make the reduction of tobacco use among its youth its number one health policy goal.

More people die from tobacco poisoning each year than from exposure to asbestos, yet the handling of removal of asbestos is more highly regulated than tobacco. We've banned the use of asbestos and evacuate entire buildings if even a trace is found. We force people to wear space suits when removing asbestos. Yet we allow children to breath in tobacco fumes in restaurants and other public places. Tobacco is still treated in many circles as nothing more than a nuisance, a bad habit, instead of a killer. Would any of us allow our children to come within even a mile of asbestos? Not a chance. For historical reasons, tobacco has been treated differently, but that is ancient history. We know that tobacco is a killer.

There are more women than men smokers overall, and the smoking rates for young girls are higher than for young boys. Young girls are the future of the tobacco industry, and how does the tobacco industry thank them? By addicting them to a health hazard worse than AIDS or suicide when measured in death and disability. Last year lung cancer overtook breast cancer as the leading killer of Canadian women. It is our duty to prevent our children, our girls and our boys, from taking up a deadly habit. We know that smokers rarely take up the habit after age 20.

1440

As doctors, we've heard it all before. At first they'll tell you they were only curious, maybe imitating a parent or a role model who smokes, or they'll tell you it was because of peer pressure. They tell you not to worry because they only smoke to be sociable, that it's only a passing fad, a stage in their lives. Others will tell you that smoking is a way of exercising their independence, but then they become dependent and they come to us because they're hooked.

It is the most difficult part of my job, watching a patient slowly suffocate to death over 10 or 20 years because of emphysema. It's not a very glamorous way to

go out, sitting in a chair for the rest of your days, not able to even walk to the bathroom on your own. A smoker's last years of life are often out of the public view, restricted to their homes and too short of breath often to do anything but sit in a chair, unable even to walk across the room to pick up their grandchild.

We see it daily and we're angry. We want action and prevention is the only way to go. We must drive home the message that today's teen smoker is tomorrow's statistic. Teens live in the present. They refuse or can't imagine that the decades of abuse will ever catch up to them. Teens are not invincible. The effects of decades of smoking will eventually catch up.

In the case of smoking, a harmless curiosity becomes an addiction. Most of today's smokers will die from smoking-related diseases. Let's not give our youth a chance to get hooked. There is nothing glamorous about smoking. For a group that is so concerned with physical appearance, smoking is probably the most gross of all habits, but it's far worse than just smelling bad or having yellow teeth. Nicotine is the most addictive drug of all, and we know it's not just a high school thing. According to one US study, only 5% of high school seniors who smoked believed that they'd be smoking five years after graduation, yet on average 73% were still smokers eight years later. So what can we do?

Let's face it, tobacco products are toxic and they kill, but look at how tobacco products are sold and advertised. They're packaged like candy or ice cream in bright, eye-catching colours. Let's show youth that there is something different about tobacco products. We support plain packaging. It is deadly, it should look deadly. It would be easy to condemn pharmacies, but the medical profession knows all too well the power of the tobacco industry. When it gets you, it never lets go.

Tobacco manufacturers were once welcomed at medical conventions. We even allowed them to pass out products by the carton to our members. We used to get our smokes for free and we snapped them up like candy. Tobacco manufacturers loved doctors because our silence was an endorsement of their product. They even used doctors as spokesmen. It was in their interest to associate cigarettes with health providers and health facilities.

We made mistakes but we broke the habit and pharmacies can too. We wholly support the move to ban tobacco products from pharmacies. Health care providers cannot on the one hand condemn the use of an addictive and deadly product and on the other hand profit from it. What are we telling our youth by allowing pharmacies to sell instruments of death side by side with products that cure you? This paradox is not lost on youth. They see the contradiction, and so with me. Pharmacies are the tobacco industry's last link to the health care system. Let's break it once and for all.

Members of the committee, we must not, and I repeat, we must not, trade the lives of our future generations for profits from tobacco. The law prohibiting the sale of tobacco products to minors needs real, meaningful enforcement; otherwise it simply won't work or make a difference. Kids will tell you buying cigarettes is as easy as buying a bag of chips. They're sold on the street and



in school yards, they're sold under the counter in restaurants and convenience stores for as little as \$3 a pack. They're smuggled in trucks and in cars. Single smokes sell for 40 cents in corner stores, at least my children tell me that.

It is important for tobacco retailers to become an integral part of eliminating tobacco sales to minors. If you are to meet your stated goal of reducing tobacco use among teens by 10% by the year 2000, then we urge you to follow through on some of your original proposals and goals: Prohibit smoking in all public places except where exempt by regulation; consider licensing of tobacco retailers if the statutory prohibition has not worked after one year; ban kiddie packs by way of additional regulation; ban chewing tobacco.

The government is seeking to devote more emphasis to illness prevention, health promotion and community care to promote a higher level of health and wellbeing and as a means to curb health care costs. Let's get tough with the people who cause millions of dollars in tobacco-related health care costs and seek to hook our children while still minors. Thank you.

**Mr Arnott:** Thank you very much. Your presentation is very blunt and direct and we appreciate that. Like you, I think there should be generic packaging on cigarettes. I'd like to see the package in black and I'd like to see a very, very blunt, direct warning. This bill seems to include provision for that possibly happening by regulation, but it's not there in the legislation. Do you think it should be?

**Dr Dickson:** Absolutely. Plain packaging, we know that the single appearance of a brightly coloured cigarette package on a table, in a school yard, wherever, is a constant source of promoting the product. The colours themselves promote the product. We think that plain packaging should be used as a way of discouraging and showing that in fact tobacco products are not a glamorous thing, that they're a dangerous product and should not be promoted.

**Mr Arnott:** Like you, I think it's extremely inconsistent as well as probably ethically indefensible for pharmacists to be selling tobacco, although their argument I think is valid when they say, "If you take away our right to sell tobacco, it's not going to, in a large way, limit the access." I think they're correct in that. Do you have any comment on that?

**Dr Dickson:** Yes, they are correct. It will not limit the access in the short term. But let's face it, we'd like to see reduction of current smokers and see people quit, and you continue all of those measures if you can. But most important, we have to stop people from becoming addicted to tobacco products in the first place. We know that people usually don't start after age 20, so you have to target children and teenagers.

If preventing them and cutting that link between pharmacies and it's a health product and tobacco's okay because they're sold together, if that somehow can cut down on addiction of our children to tobacco, we'll have a whole generation of non-users in the future, it'll save us a fortune and it certainly will be good for the health of this province.

**Dr Ted Boadway:** If I could add, I think we do well to remember that with kids, you or I giving them a lecture doesn't work very well when they're 16, 14, whatever. They're at the age where they're refractory to that, at least my kids are for me. That doesn't work. They're at the age when they're at their maximum resistance to education. They're at an age where image and association is the method of aspiring and the method of learning.

Image and association is what the tobacco industry's linkage of tobacco and the health industry is all about. If it's important to the tobacco industry to have that linkage, then by gosh it's important to us for exactly the opposite reason.

**Mr Arnott:** You've suggested we take away Pat Borders's chewing tobacco. I guess he's going to ask to be traded and maybe half the other Blue Jays too, so that's politically dicey.

Is there as direct a link or as clear a link between chewing tobacco and cancer as we see through smoking tobacco and cancer?

**Dr Dickson:** Absolutely. I can speak personally on this. I am an ear, nose and throat surgeon by training, and there's no doubt that the incidence of cancer in the oral cavity, tongue and the side of the buccal mucosa where they hold their pouch, is seen essentially only in people who chew tobacco—you will see it in other tobacco products but that particular cancer in the side of the mouth, and it's actually right in the very spot where they hold their chew, so to speak. So the link is very strong.

**Mrs Haslam:** Who is Pat Borders?

*Interjections.*

**Mrs Haslam:** I come from Perth. Just because I live here four days a week doesn't mean I watch ball all the time. A pleasure to see you, Dr Boadway and Dr Dickson.

I wanted to ask you a question because I read a lot of things that come to this committee and a couple of very interesting letters have come my way. This one brings up a particular issue, and I know that Mr White has a question around some other issues, so I'll ask one quick question.

**1450**

This came from the Sunnybrook Health Science Centre. They were concerned about veteran residents of facilities such as Sunnybrook Health Science Centre because of their inability to walk and their mobility difficulties. They were concerned about putting an exemption in place to purchase cigarettes on site, and to expect physically and cognitively challenged smoking residents to access cigarettes outside the facility would pose a major risk management issue.

I just wondered if you had a comment on that, because I asked whether this might be an exemption case and I just want the Ontario Medical Association's comments on this particular issue.

**Dr Boadway:** Geriatrics was the field in which I worked when I was in practice, and I must say that this argument tears at me a little bit. First of all, you have to recognize that the reason a lot of those veterans are



limited and can't walk is because they smoke. This is absolutely astonishing. People whose lives are just about over because of their addiction still have a compelling need to find the product. As a non-addict, I always have difficulty with that.

In nursing homes we've had the prohibition for years of not being able to smoke in the residents' rooms. In my own nursing home we had some deaths due to fires due to smoking in bed—it's a terrible tragedy—before the ban was brought in. We in the nursing home industry supported the ban of smoking in residents' rooms completely. It was hard on some of the residents because some of the residents had such bad emphysema they could hardly walk from their bed to the smoking room. But did you want them to burn to death, or what?

As a matter of fact, one of my patients who was so sick she couldn't get to the smoking room finally got well enough, because she was prohibited to smoke, that she was able to get to the smoking room. She smoked, it fell on her clothes, she was burned, and as she was carried out she said, "Dr Boadway said my cigarettes would get me one way or the other." She had a sense of humour. She died from her burns.

**Mrs Haslam:** So you feel that there should be no exemption for this particular issue and case.

**Dr Boadway:** I am afraid that, having lived fairly close to it, I have difficulty thinking there should be exemptions.

**Mr White:** I wanted to get back to the issue that you brought up, Dr Dickson, in regard to the free cigarettes, the enticement of doctors, as health professionals, to smoke that was pretty insidious and pretty effective in the past.

I can certainly remember advertisements from an American company that one out of 10 doctors smokes Camels, or whatever the heck it might have been. The idea is that if a medical or health professional such as yourself is smoking Camels, or whatever brand it might be, then clearly these are good cigarettes, they're healthy.

You, as an association, are clearly saying it's not a good idea and you are clearly, as an association and as a profession, indicating that a poisonous and toxic substance such as this should have no part in the dialogue between a patient and yourselves. Yet we have still that one conflict in our community with the pharmacists, who are a regulated health profession, the only place where you can buy drugs. It seems such an obvious conclusion that that should not occur. I'm wondering what your experience is with pharmacists who have spoken to you on this issue.

**Dr Dickson:** Firstly, we know that it has been a direct tactic and a strategy adopted by the tobacco industry in the past to get health care providers to, in effect, endorse its product and be spokespeople for its product. That was seen back in the 1940 and the 1950s, and they targeted physicians. Ten per cent of the doctors in this country now are smokers. We've reduced it rather dramatically. We were one of the heaviest users and now we're one of the lightest, if not the lightest, users. We've banned tobacco use at all our meetings and in all our association

offices. Failing physicians being the obvious link, the last link in that chain now that remains is in fact the pharmacy. That's the only health care provider facility that's involved in the dispensing of tobacco products or promoting them, not necessarily actively but tacitly. They're in the same room, they're in the same area, and the linkage is quite obvious. We simply can't support that. It's just an insupportable activity on the part of pharmacists, we believe. It simply should stop.

**Mr White:** Wouldn't making this message very clear, that no health profession is involved, implicitly or explicitly, in the sale of tobacco, in the sale of a toxic substance such as this, make it clear throughout our province that there is no association whatsoever between this product and anxiety reduction or any other excuse for smoking?

**Dr Dickson:** Yes, absolutely.

**Mr McGuinty:** Thank you very much for your presentation. I'm sure we all agree with at least 90% of what you said. The issue of course that recurs and that I find troublesome—you know, I'd like to phase out smoking in the province over time, and I guess we have different ideas on how best to accomplish that.

You have a certain luxury, of course, that I don't have, and I mean that sincerely, in terms of being able to advance only one particular cause, so to speak, and that's the health cause. We as politicians have to be concerned with all the other kinds of concerns that are advanced by the various interest groups, things like jobs and what this means to the economy.

I just want to focus on one issue again; that's the pharmacy issue. I understand the argument that's made for having this in here is the symbolic value; it represents a social acceptability. I'm just wondering if anybody has ever obtained any empirical data as to what—do people, kids in particular, believe that it presents as some kind of an anachronism, some kind of a paradox? "They're caring for my health and they're selling me cigarettes." By the way, I don't buy into the argument at all that pharmacists can counsel you against smoking while at the same time selling the darned stuff.

Give me something to hang on to, because what's going to happen at the end of the day here is that we're going to vote on this stuff. On the one side there's a symbolic merit, and on the other side we're going to hear from some people who are going to say there are going to be some job losses. We have to weigh that. What have you got for me?

**Dr Dickson:** Let me start off by saying that about a month ago, almost to the day, this government passed legislation, the health professions amendment act, which in fact treated and accorded to pharmacists professional status, in effect. They were treated as all other 25 professions were. They were given a monopoly over the dispensing of pharmaceutical products in this province. They were treated as professional health practitioners, not as retailers.

Now the argument has flip-flopped; in fact they're using the reverse economic argument to protect a certain part of their practice, if you will, when in fact under the

RHPA they were treated as health professionals. We believe there's an inconsistency there. The argument was that they were health care providers like everyone else. Now it's that they're retailers like everyone else. You can't have it both ways.

I understand the concern about job loss; it's a serious one. But as I mentioned in my earlier comments, I do not believe that we can in all conscience trade off economic benefits for the lives of a future generation of our children. I know it's a difficult choice, but it's a profound one and I just cannot agree with it.

**Mr McGuinty:** What I keep coming back to, though, and everybody agrees, is that it's not going to reduce tobacco usage. So it's a symbolic element.

**Dr Dickson:** Just a very quick one: It won't prevent tobacco usage right today. What we want to do is stop a whole generation from becoming addicted and cut the link with the health care facility. I made that comment earlier and I believe that by breaking that link, it's much less likely. It's one of the links in the chain to prevent our teenagers from becoming addicted.

**Dr Boadway:** If you've ever had a child with an earache, you know that child suffers intensely with the earache. You take the child with the earache to the pharmacy, where they learn to understand that they can have medication which will deliver them from this raging pain. That's a high-impact event for a kid. Then when you take it to the front to pay for it, behind the counter are tobacco products. Kids do not have their eyes shut. Kids make associations. They make associations more strongly than they take lessons. So I would suggest that is a very powerful image for that kid at a time when they're maximally vulnerable with their raging earache.

**Dr Mai:** We may think that it's only symbolic at this stage, but if we don't start somewhere, we're never going to move towards a tobacco-free society. If we hedge every time we make a move and say, "Gee, we're not going to have a major impact; there will still be smoking; we'd better not do it," then we're not going to move along.

**Mr O'Connor:** I just wanted to maybe add a little point to this conversation that just took place, because I was actually going to ask a very similar question. I think that as we went through the Regulated Health Professions Act, and just before Christmas there was another health piece of legislation, the college was there and I appreciate that. It wasn't symbolic. It was something tangible, was it not? And I think the college of pharmacy was there because they wanted to be recognized as health care professions and participate in that. Is that not the sense that you feel, that the college really want to be health care professionals and not just another brand of retailers out there?

**Dr Boadway:** I'm one of the very few people who can claim to be a veteran of the entire HPLR process, okay?

**Mrs Haslam:** There are others.

**Dr Boadway:** There are a few of us who are equally nuts, but I'm one of them. I was in it for the full 11 years and I was here at the hearings with some of you. Never,

during that entire process, did my colleagues the pharmacists claim they wanted to be anything other than full health care professionals. I'm glad that's what they wanted. We accept them that way. They're welcome partners in our health care spectrum; we couldn't do without them. But that's what they are.

**The Vice-Chair:** Thank you for your presentation.

#### SOCIETY OF INDEPENDENT COMMUNITY PHARMACISTS OF ONTARIO

**The Vice-Chair:** The next presentation will be made by a representative of the Society of Independent Community Pharmacists of Ontario. Please have a seat, introduce yourself and proceed with your presentation when you're ready. Hopefully, there will be time for questions towards the end of the time allotted, that being one half-hour.

**Mr Jerry Taciuk:** While I'm getting ready, my name is Jerry Taciuk. I sit on the Etobicoke board of health. The city council yesterday made a monumental decision with respect to the tobacco act. At the board of health, it was passed 6 to 4 in support of Bill 119. It went before the council yesterday and I would like you to hear just one small comment, a very prominent politician and what he said after reviewing all the material.

*Audio presentation.*

#### 1504

**Mr Taciuk:** That's sufficient to give you an idea of what has happened. So I put out a motion to them at city council and I advised them that I'd file a motion in Ontario Court (General Division) to overturn the decision of the board of health because of misinformation that was presented to the board in making this decision with respect to Bill 119. There was a pile of information on 119 pro, but very little against. I'd say the pump was primed one way. I told them that in the event that anybody put a motion forward to the Ontario Court (General Division), they'd win automatically because of the way it was structured.

Basically, I come here with a double whammy. I'm a stroke victim from tobacco. I smoked for 25 years, two, two and a half packs a day. I've got no feeling in my hand, so I would like some water that I could put on to turn the pages. So I know from both ends what it's like. Notwithstanding that fact, my siding with the OMA—I agree with them, I agree in principle with them, but I don't agree with the methodology. I don't think—Dr Kaplan or Sadock have prepared psychiatric textbooks. It's an addiction. We'll now come to that in a little while.

Basically, I'm with the Society of Independent Community Pharmacists. I was a founding director back 10 years ago. I was asked to do this, and Mr Musial sends his apologies; he's in Aruba lying on the beach. He leaves me with this.

But my experience at this committee—the reason I came back was, after Bill 100 with respect to sexual abuse, I had so much fun with that one and I was very discouraged that it would appear that the Legislature had had frontal lobotomies when it came to the legislation, because Premier Rae tabled this legislation without the minutes of Hansard being released. I contacted the



Premier's office and told him, "How can you allow the members of the Legislature to make an informed decision when there are no minutes yet?" I got a call back. This precipitated three calls from the Premier's office that one day. They said, "Well, there's Instant Hansard." Then I called the Clerk of the House and I found out Instant Hansard is only distributed to you people here, not to the Legislature. So after that, and after seeing what has been going on with this Bill 119, I decided—I heard that the chief medical officer of health may try to establish a correlation between sexual abuse and tobacco, so I decided I should come here.

You'll find out later what this stands for.

There is concern of what has gone on in the past. As I stated, I am disabled, and proof from the tobacco aspect. I'm under Canada pension. It says I'm not able to go back to work as a pharmacist. Counselling is now recommended because I can't work as a pharmacist. I have "problems with complex problem-solving, attention, concentration, mental flexibility, abstract reasoning." But I love this one. It says that, "The patient is alert and well-orientated...above-average intelligence." This is after my stroke. Boy, I would have been good before the stroke; I would have torn you apart.

But anyway, I have problems with the memory, I really do, and I have the numbness. I'll tell you, if you have a stroke, there's no feeling to—you can't describe it. I was sitting on the veranda doing what I did best, smoking, and I looked down and my hand was paralysed. My face was drooped. I tried to get into my house. I tried to open the screen door and I didn't know—we'd lived there 20 years and I didn't know there was a button on the door. I was shaking the door and finally got it open. I got into the house and couldn't find my way around. I didn't even know where I was. I'd lived there 25 years. I finally found my wife, and she said, "Well, you've probably got some circulation—go put water on it." I reached for the taps. The taps were here, my hands were here, trying to turn a tap that wasn't there. So try that. I'll show anybody these reports and ask you to bear with me, because I do have a problem with correlating. I lose papers left, right and centre. I'll probably lose my keys before I get out of here.

What the concern is: Bill 119. What are we here for? Well, I can tell you why we're here. The Ontario College of Pharmacists has the power under the Health Disciplines Act to initiate regulations to do that which they want it to do, but the government wouldn't get the joy, and blowing—I don't know how much these committee hearings are going to cost us, but we're paying for them. So when the college says to me, "We came. We wanted an act," of course, I'd want an act, too. It's easier. You don't take the heat.

1510

Now, with respect to the college and their power, you look at the letter from Dr Truong, who is here. There's a list of people in this, pharmacists who support Bill 119. If you look at them, they're all educators, okay? Educators, not retailers. That's very important. Number two: Their letterhead misleads the people looking at the letterhead into thinking they're in a different position.

Past-president means you've been president; but you are still on the executive and you are still making executive decisions. These people are so far past that they're in history, but the people at my board of health were of the opinion that they're all past presidents. They say, "How can you have five past presidents running at the same time?" This bothers me.

Dr Truong indicated that he ran for election in 1992 and he was defeated. This is from the pharmacy publication, "Truong nearly lost his seat on OCP. He believes it should be booted on the tobacco stand."

What that tells you is, the support is not there. Had there been support, Dr Truong would still be at the college, so the issue on the tobacco is not what we think it is.

Also, there was another issue at the college at that time, Premier Peterson wrote to us and I've got the letter here. I can show you. Here it is:

"Dear Mr Taciuk:

"Thank you for your letter. I understand that the staff of my office and the Honourable Elinor Caplan met with you. We are aware the governance of health professions needs improvement."

There were problems at our college a long time ago, probably 50 years ago, and a former minister of this Legislature, the Honourable Mr Leluk at that time, had written a thesis on this—all the problems at the college, so it's nothing new. There were problems. Tobacco is not one of the problems and it's not going to solve the problem for them.

My contention is—okay, let's put it where it is—here's another example: The chief medical officer of health; I believe his name is Dr Schabas. It is my respectful submission that Dr Schabas is one of the chief lobbyists on Bill 119 this province has ever seen. He openly comes out and lobbies. He sent a letter to medical officers of health in the province stating that if any pharmacy group comes to you about the sale of tobacco, contact me and I'll provide you the information. Isn't that amazing? Here's our chief medical officer—you know what that tells me? This legislation's going right through that Legislature and everybody's going to be lobotomized and it's going through, because if Dr Schabas is involved, turning the screws and providing false information, what else is going to happen?

I contacted Dr Schabas. He stated in his letter to all the medical officers—I have a copy of that—tobacco kills 13,000 people a year. Isn't that amazing? That's a lot of people. He said he's going to stop that. We won't have people dying from tobacco. Great.

I said to him, "Is that what your primary motives are?" He said, "Yes, and if we get it out of pharmacies, that's going to help." I said to him: "You're so concerned about the life of the province. Not that I'm a pro-lifer or in favour of abortion, but why are you allowing 43,000 babies, unborn fetuses, to die—because you told me, 13,000 die from tobacco and you're concerned about that. Let's turn it right back." So his argument does not hold any water at all. His purpose does not hold any water.

I would respectfully suggest that this legislation has



nothing to do with tobacco and utilization. My contention is, there's a battle between a major tobacco producer and a major pharmacy chain. The chain's got nothing to do with it; neither has the tobacco. But why would Dr Schabas get himself involved?

Another example: ALOHA is an association of health organizations, right? Dr Jaczck will be here today. The question to ask her is—it states here: "The promised tobacco act is intended to prevent this from continuing to be the death of the next generation." What about the babies? Let's ask that.

"We call on the members of the Legislature to ensure that this legislation is brought forward and passed." You know what she did? She sent out and got every medical officer of health of this province—why've I got this? Because I'm on the board of health. Look, they all signed. They supported it. You know what? The legislation to my knowledge wasn't released yet. Isn't that great? No legislation, but they signed.

I brought it up at our board of health. You know where it is? They didn't put it in the minutes. It's not in the minutes for the meeting that we went to on this one.

Here's a beautiful one to Dr Jaczck from campaign on tobacco—one part. "Prior to the act's introduction many of you wrote and telephoned." It said that "the NDP deserve a pat on the back on this legislation." You don't pat until you're finished, unless we're going to be driving right through without even having any problem. I don't know.

Okay, the next one is—I was very pleased to see this brochure here, because that tells me that the government is now concerned the legislation may have some rough running through the Legislature.

#### *Interjection.*

**Mr Taciuk:** This is the one here—through the Star. It's a beautiful thing about children: how we deal with them, how we do this. But you know, this thing here is not consistent with the textbook on psychiatry. The ministry—the way they designed it, it's nice. But one thing the government did admit—and it's at the very end, about the addiction properties—is that it's highly addictive. It's worse than heroin for addiction and you want to take it out of the pharmacy. That's going to really solve the problem, isn't it?

I'll tell you what. I went to Europe. I was a smoker then. You had to go to a tobacconist's shop. I remember driving all over the place and I'd kill anybody if I could get a cigarette. That's how bad it is.

The way we brought it up at our board of health is, our chairman has a plaza near his home with about 10 stores: one store's a pharmacy; two doors away is a variety store and two doors from that is the little grocery store. So he looked at it and he says, "Well, if they take it out of the pharmacy, I can still go two doors away or there." But then he says that if this fellow leaves—it's all senior citizens in the area; they walk to that pharmacy to get their prescriptions; walk. The chairman, that's how he changed his mind on this bill. He was supporting it until I said: "Go down there; you live in the area; go look it out. Don't even talk to the pharmacist; just look it over."

Another thing that bothered me—I'm totally against tobacco, but I am against control and treating people like kids. We will make the informed choice. I made the informed choice to die. For some reason I didn't die; I had a stroke. Next time I'll die. But we make the informed choice. The government is not going to be my keeper. They may think they are and they're going to legislate me to death, but it's not going to do any good.

This is the kind of stuff that's coming out—running down—shoppers this and shoppers that. But you know what the issue—Mahood has not talked about how it's going to reduce tobacco utilization. Everything I got from our board of health that was put on our plate is criticism, criticism: These people are married to these people. These people are sleeping with those people. Who cares? Tell me how the legislation's going to benefit the public of this province. Tell me that. You won't find anything.

Mr Mahood brings out in the paper, when they're talking about the reduction in tax on the tobacco—I love his comment that it would lead to revenue loss of hundreds of millions of dollars which will have to be replaced with something else. I thought he was concerned about smoking and health. He's telling about taxes and bucks now. I don't know. That's another one.

I better put this down because this is the society's view. "The society is supportive of curtailing the use of cigarettes"—this is a letter that they sent to the mayor of Etobicoke and it gives their position—"and their distribution. We are also supportive of any program or legislation that will deter our young persons away from smoking. However, the government's proposed legislation does not address any of these problems whatsoever. The legislation merely removes pharmacy as one of the links in the distribution chain for tobacco in Ontario. It is the government's ultimate goal that by removing pharmacy as one of the links in the tobacco distribution chain it would show somehow curtailing of distribution; there's ample evidence that this will not occur."

**1520**

That's the position of the society. I read you Dr Schabas's thing.

Here's another non-smoker's letter, to a councillor in Etobicoke, not saying how the legislation's going to benefit. He says, "I believe the committee of independent pharmacists is a front for the tobacco industry." What's he talking about? Hasn't he got anything positive to say about the legislation? Anybody can go and personalize and attack people.

This is signed by Gar Mahood, and then at the bottom he says, "I do regret I am unable to appear personally at council." He takes a shot and then he runs.

Then here's another one: "We believe the committee of so-called independent pharmacists is either a front for a group of chain stores or Shoppers Drug Mart." No proof. Won't come to the meeting, though.

I think I'll just move to the last part. The college thing is very important; I can give you the regulations of what it is. But they had the opportunity. They could have done it, but they didn't do it, and it is my firm belief that all we're doing is going through the motions to give the

government a big pooh-hoo when it pulls this legislation off. It will be another Bill 100. Then they're going to turn around and say, "Oh, colleagues, you make the regulations for this." There will be no act.

This is where I differ from the medical association. As I said, it's a very, very addictive drug and the idea about teenagers—they don't take that, in this book, to be full gospel. Just one second.

Another thing, if you're so concerned about tobacco, do you know that you've got the same problem with caffeine? It's a highly addictive substance, and here it outlines what the problems with caffeine are. But the tobacco issue—"Tobacco dependence is defined as persistent tobacco use, despite the person's psychological distress at the need of repeated use."

What causes it? They say that a kid grows, he's going to automatically become—here they don't say that, but what they do say is, "Causes: The initiation of tobacco use seems to occur predominantly through social reinforcements." That's where it starts, and it doesn't matter on age.

Tobacco dependence, I don't know if you knew what some of the effects are: anxiety, guilt, shame, anger, counterattacking people. But on the withdrawal, it's really bad. The most common symptoms are irritability, restlessness, sleep disturbances, headache, impaired concentration, memory anxiety. Would you like these people driving a car?

The college is saying, "Take it out of here; we don't want it." You know what? They should be saying: "We want to counsel these people. It's a psychiatric problem. It's serious." Why the hell, excuse my French, do you want to give it away and send it away? Is that what we do in pharmacy? Send their problems to somebody else? The OMA is saying the same. Why is the OMA? The government has given them the right to incorporate.

Also, in this book they turn around and state—

**Ms Sharon Murdock (Sudbury):** Could you give us the correct title of that book and the year it was published, please?

**Mr Taciuk:** As I come near the end, okay? The concern is that physicians are now coming out of the woodwork and saying, "Hey, we've got a real problem; we're going to really fix this up," right? But you know what it says in here? "Most cigarette smokers state that they have never been advised by a physician to discontinue." I checked out 50 people I talked to who smoked and I said, "Did your doctor ever tell you to stop smoking?" "No." But the ones who quit, they went to their doctor to quit.

Another reason would be, a doctor is like me. He's a businessman. You don't chase the customer away by giving him what he doesn't want.

If the physicians were so concerned about this, they should also—as he says in here, "Let's start counselling." It's an addiction. Don't go and throw it down the tubes and pass it on to somebody else. You start telling every patient who walks into your office. The pharmacy—it's not going to do nothing in here, absolutely nothing.

The treatment here, they say, as a supportive approach

is the only way to go. You have to be supportive. Who can be the most supportive? The pharmacist.

The most important aspect, I forgot to mention, is the effect of the drugs on this. Any person using medications—tobacco has a drug metabolizing effect, so people using psychiatric drugs, chlorpromazine, anti-depressants, their dosages will have to be regulated. What are you going to get: Becker's, Mac's Milk, the corner store? They can't do it. Why is my college saying, "Don't sell tobacco in here"? As long as you've got those people coming in, you're going to be able to talk to them. We have to realign our thinking in pharmacy to the patient and not throw the baby out with the bath water. There's a serious problem with tobacco, and I agree. The pharmacy has to be regulated to take part in this. I think that's all I can give you on that.

The name of the book is *Modern Synopsis of Comprehensive Textbook of Psychiatry/III*, by Harold Kaplan, MD, and Benjamin Sadock. I will leave one copy of documents with the Vice-Chair and you can distribute them as you can.

But I would implore you not to allow this to be used by government or anybody as a means to change the system. As Councillor O'Rourke said, you don't move into somebody's turf like that without knowing what you're doing. Basically, that's what he's trying to say. I hope this Legislature will do the same and tell pharmacy they have to keep tobacco and you're going to start counselling everybody, even if you have to put the tobacco right in the dispensary. I thank you.

**The Vice-Chair:** We're almost out of time, but are there any questions?

**Ms Murdock:** Just one; more of a comment, I guess. In my riding of Sudbury we have a pharmacist in Copper Cliff, part of my riding, who upon graduation as a pharmacist never sold any tobacco in his store. Many of my pharmacists—in fact, almost all of them—have agreed with the recommendation that came out from the college of pharmacists two years ago to voluntarily remove tobacco products from their stores. So I am sort of surprised by your presentation today in the sense that I'm wondering who you represent.

**Mr Taciuk:** I forgot to tell you. I started consulting probably the time McDonald's started. In 1969 we were written up in the *British Pharmaceutical Journal* for the first pharmacy that had been consulting—we had no front shop. We were written up in the *Canadian Pharmaceutical Journal*. We have been in the world bulletins for what we have done. But I see it differently. I see it as an opportunity, with an addiction—and another reason, too, which you brought up: If you are in a clinic, the only thing you want is that piece of paper, that prescription. I had clinic operations. I had two of them. I didn't need tobacco. I didn't need drawing cards. My drawing card was the doctors upstairs, and I got the piece of paper downstairs. They didn't send them to me, but they had to come down the stairs, and to get out the door they had to walk by me. So you have a different philosophy.

**Ms Murdock:** So you represent consultants to pharmacists but not pharmacists.



**Mr Taciuk:** No, I don't represent—I started the Society of Independent—now, that group, the other group that sent things around—

**Ms Murdock:** Who is your membership? That's what I want to know.

**Mr Taciuk:** The membership is pharmacists around Ontario. It's a very small group and we're not associated with any group that represents—called the committee of independent pharmacists. The society of independent pharmacists was formed at the time of Murray Elston during Bill 54, Bill 55, and the Senate bill 92 when we appeared in the Senate. It was formed as a cohesive group that had likewise philosophy. As I state, numbers don't mean anything. If you want to talk numbers, we're talking philosophy. We're talking, will legislation work? If one person can bring out a point in legislation, if you've got 1,000—like I showed you, the college: Now, Mr Truong, if his group represented as much as they did, he would have got re-elected. So numbers don't count is my opinion.

**The Vice-Chair:** Thank you for your presentation.  
1530

#### PHARMACISTS IN SUPPORT OF BILL 119

**The Vice-Chair:** The next presentation will be made by representatives of the Pharmacists in Support of Bill 119. Would you come forward please, introduce yourselves and proceed with the presentation. Hopefully, there will be time for a few questions when you've completed your presentation. Good afternoon and welcome.

**Mr Jim Semchism:** Good afternoon. My name is Jim Semchism. I'm a pharmacist-owner from London, a past president of the Ontario Pharmacists' Association—that's the voluntary body for pharmacy in the province—and co-chair of the group known as Pharmacists in Support of Bill 119.

I am joined by my co-chair, pharmacist Nghia Truong from Ottawa. Nghia is a past president of the Ontario College of Pharmacists—that's the regulatory body—and played a key role in the development of Bill 119, the Tobacco Control Act, which proposes to ban tobacco sales in pharmacies in Ontario. I am also joined by Margaret Frankovich, a pharmacist-owner from Whitby. Margaret is one of our founding members. She appeared with Nghia and myself at our opening news conference at Queen's Park in December.

On behalf of our group, we would like to formally congratulate the government for forwarding the Tobacco Control Act. We support all of its major initiatives and urge the Legislature to pass Bill 119. We are especially pleased that the province has chosen to respond positively to the request from our own licensing body, the Ontario College of Pharmacists, to suspend the sale of tobacco products in pharmacies.

The founders of Pharmacists in Support of Bill 119 include three former presidents of the Ontario College of Pharmacists, two former presidents of the Ontario Pharmacists' Association, the executive director of the Canadian Pharmaceutical Association, the dean and acting dean of the faculty of pharmacy here at the University of Toronto, a former registrar of the Ontario College of

Pharmacists and several other prominent community and hospital pharmacists.

Our group has four basic objectives:

(1) To support the 1991 request from the Ontario College of Pharmacists for legislation to terminate the sale of tobacco products in Ontario pharmacies;

(2) To support the passage of Bill 119, the Tobacco Control Act;

(3) To inform the public that many Ontario pharmacies have already removed tobacco products from their stores, some in response to a series of requests from the Ontario College of Pharmacists dating back to 1989, and that others have never sold tobacco products;

(4) To educate the public about the incompatibility of pharmacy as a health profession being involved with the sale of tobacco products.

Margaret, Nghia and I own pharmacies where tobacco was sold. We removed tobacco products from our stores during the 1980s and have remained successful health professionals. The discontinuation of tobacco sales in our stores did not lead to our demise. Unfortunately, voluntary removal of tobacco, as endorsed by the Ontario Pharmacists' Association, has not occurred in all pharmacies.

Since our initial news conference here at Queen's Park on December 10, 1993, our group has prepared and sent a letter of introduction, a membership form and a survey to every pharmacist in Ontario. Most of our colleagues have just recently received this correspondence, and we hope to share with the committee our membership numbers and survey results at either the hearing in London or in Ottawa. A copy of the survey is attached to our documentation. Our activities are funded entirely by the generous donations of pharmacists who support our objectives.

We have been active for the past two months meeting with our allies in the health advocacy field. Our efforts have been endorsed by many organizations, such as district health councils, public health units, medical officers of health, local chapters of the cancer society and the lung association, the Canadian Pharmaceutical Association, the Non-Smokers' Rights Association and the Ontario Campaign for Action on Tobacco. We are grateful to all these organizations for their support and advice.

In response to correspondence sent to over 500 Ontario municipalities by the Committee of Independent Pharmacists, CIP, we have written over 130 municipalities in the province urging them to support the proposed ban. In its letter to each municipality, the CIP claims to "represent 1,420 pharmacist-owners in Ontario who sell tobacco products." In reality, there are only three members. In an interview in the January edition of the Pharmacy Post the following paragraph is printed, and I quote: "Just the three of us are the committee," Rosen admits, adding they felt any independent pharmacists who currently sell tobacco products 'would support us.'"

They also told in the letter to the municipalities that, "Approximately 300 pharmacies will have to close, up to 10,000 jobs will be lost and the remaining pharmacies



will have to downsize....As time goes on, the commercial tax base of your community will be adversely affected."

There is no rational basis for this preposterous assumption.

In response to the CIP's unfounded projections, several town councils passed motions against the proposed ban before receiving our letter on the subject. Most groups passing motions of support were from small towns, counties or townships with the exception of Sault Ste Marie, Niagara Falls and Brockville. Rather than catalogue each of the councils in opposition to our cause, I would like to highlight two interesting cases.

In southwestern Ontario, the town councils in Mitchell and Petrolia passed motions decrying the pharmacy tobacco sales ban. In Mitchell, the only pharmacy in town does not sell tobacco. The pharmacist-owner was not contacted by a single councillor before the motion was made. In Petrolia, there are two pharmacies, a small clinic dispensary that does not sell tobacco products and a large chain pharmacy that does. Neither store was contacted before the motion appeared at council. In response to press coverage, the manager of the chain store wrote the local newspaper to outline his personal support of Bill 119 and that of his company. Neither pharmacist was contacted by Petrolia's councillors. One of the councillors in Petrolia told the clinic pharmacist that he assumed that the Committee of Independent Pharmacists was really the Ontario Pharmacists' Association, based on their claim of who they represented. It is essential that the social development committee does not fall into the same trap.

Attached to this presentation are copies of the Committee of Independent Pharmacists' letter and our response. You will note that their predictions of job loss, pharmacy closings and the loss of municipal tax base are without substance. We challenge them to show the committee how they arrived at these numbers and conclusions. Hundreds of pharmacies in Ontario have stopped selling tobacco products without serious economic consequences. The Canadian Pharmaceutical Association study in 1992 also confirms the fact that many pharmacies removed tobacco without serious economic consequences.

In our own pharmacies there were no job losses, no downsizings and certainly no pharmacy closings associated with the discontinuation of tobacco sales. The CPhA study results reaffirm our premise that the economic impact on pharmacies is minimal. I believe that the committee will also be receiving the results of a Coopers and Lybrand survey commissioned by our opponents. It is my understanding that this study will predict job losses in pharmacies of 2,700 and pharmacy closings of about 130. This survey defies the experience of hundreds of independent pharmacies who voluntarily discontinued tobacco sales in the last 10 years.

The CPhA study of 56 real cases of pharmacies discontinuing tobacco sales does not support the Coopers and Lybrand speculations. Even if the Coopers and Lybrand figures were accurate, the three pharmacists claiming to be the Committee of Independent Pharmacists grossly overestimated the impact by factors of two or three. Unfortunately, municipalities appear to have accepted misleading, unscientific data. It is truly unfortu-

nate that many municipalities responded to the CIP's propaganda. Again we urge the committee to view the issue from a more informed perspective.

#### 1540

The Committee of Independent Pharmacists does not represent independent pharmacy in Ontario. Hundreds of independent pharmacies have voluntarily stopped selling tobacco products in the last 10 years. Hundreds of independent pharmacies in Ontario have never sold tobacco products. I believe that hundreds of independent pharmacist-owners currently selling tobacco in Ontario are in favour of the legislation, Bill 119. Many have stated that they will gladly discontinue selling tobacco when a level playing field is created by the province. The president of Ontario's second-largest pharmacy chain, Big V Pharmacies Ltd, Mr Norm Puhl, made the same comment to the media in November. He stated that his 125-store chain was in favour of the pharmacy tobacco ban, that they supported Bill 119 and that they looked forward to the creation of a level playing field.

Let me state once again for the record that pharmacy does not need tobacco sales to survive.

Any reasonable pharmacist readily admits that the health of Ontario's citizens will improve if tobacco use is curtailed. Removing tobacco from pharmacies eliminates a conflicting message and continues a very rational move towards a smoke-free Ontario. Those who promote this myth are not using logic. First, pharmacies are health facilities. Pharmacists are health professionals, educated to promote health and prevent disease. Pharmacists should want everyone in Ontario to stop smoking. Our opponents appear to believe that if this occurred, pharmacy could not survive.

Smoking is the single most significant cause of preventable illness and premature death in the province. Why would any health professional want to be involved with the sale of a product known to increase the patient's risk of stroke, cancer of the mouth, cancer of the larynx, cancer of the oesophagus and cancer of the lungs? Smoking leads to ischaemic heart disease and circulatory diseases. Smoking contributes to bronchitis and emphysema. Smokers are more vulnerable to gastric and duodenal ulcers, as well as to bladder and kidney cancer. Smoking during pregnancy increases the risk of spontaneous abortion and low-birth-weight babies.

These are all well-known facts. It is clear why our licensing body called for a ban on tobacco sales in pharmacies. How can pharmacists who call themselves health professionals appear before this committee and argue against our college's rational request for legislation to ban the sale of tobacco in pharmacies?

Pharmacy loses credibility when pharmacists try to defend the sale of tobacco on legal and economic grounds. Pharmacy survives throughout Europe without the stigma of tobacco sales. It is time for North America to wake up. Our members applaud our licensing body and the government of Ontario for developing legislation that will remove tobacco products from all pharmacies in this province. This is precedent-setting legislation for North America and will be duplicated across the continent.

Late last Saturday evening, I received an after-hours request to open my pharmacy to fill a prescription for a two-year-old asthmatic girl. The girl's father brought me a prescription written in a local hospital's emergency room for a steroid inhaler. He told me his wife was also asthmatic and that she had used a similar inhaler. While counselling him on how to use the device, I asked him about tobacco smoke in his home as a possible irritant to his family's asthma. He admitted to being a heavy smoker. He was coughing and complaining about the cold air outside. How would a pharmacist who sold tobacco have resolved the ethical dilemma that they would have to face? Profit from the sale of tobacco, profit from the sale of medication used to treat the adverse effects of tobacco consumption: clearly a conflict of interest. How often are health professionals confronted with smokers seeking medical attention for conditions caused by or exacerbated by tobacco smoke? No health professional's income should be dependent on the sale of this deadly product.

I would now like to call on Nghia Truong to describe the efforts of the Ontario College of Pharmacists over the past several years to remove tobacco products from pharmacies.

**Mr Nghia Truong:** Good afternoon, ladies and gentlemen. Let me first thank all the members of the committee to give this group a chance to talk with you. Let me make one thing clear right from the start. Maybe you have heard my name about being the president of the college; it's the past. I'm no longer on council. I speak of what happened at the college when the genesis of the pharmacy part of this bill came about.

I have to go back to when I first came to Canada. I was trained in Europe as a pharmacist—in France, to be exact. As all of you know, you can walk into any pharmacy in Europe and you will never find tobacco. You can walk into a pharmacy in Asia, in countries that we call developing countries, and you would never find tobacco in a pharmacy. So I was quite shocked when I first came to Ontario.

The only thing people told me you can do is for you to be inside the process. You can scream from the outside and it will never happen. That's when I became a member of the Ontario College of Pharmacists in 1984. Back in those days selling tobacco was quite natural, and of course pharmacies and drugstores in a North American setting carry everything from soup to nuts.

When I put the question of tobacco to my colleagues on council, I got the answer: "This is a legal product. So it's all right; don't worry about it." But I cannot say I don't worry about it. My training as a health care professional would prevent me from saying that.

I kept on plugging with the college and I made a personal decision which I will tell you when you will be in Ottawa, in taking out tobacco in all my pharmacies. Contrary to what you may have heard, I used to have a large store, a 5,000-square-foot store, not a small store. We carried tobacco and it's a large amount of revenue which I lost; it's not a small amount. So whatever you heard this afternoon may not be correct but I won't go into details.

I took tobacco out of my stores. I used to have four stores, by the way. My wife's own pharmacy—she's a pharmacist also—never carried tobacco, so that's the end of the story there. She's smart, I think.

**Mrs Haslam:** We usually are.

**Mr Truong:** I quite agree with you, Ms Haslam. I'm told that women are very smart, and I have no problem about that.

In 1989 the college, due to certain pressures from some councillors, made a statement of disapproval. They couldn't go further than that. I won't take any credit but at least we had the tobacco issue on the agenda.

My chance came in 1990, when I became president of the college. By pure luck, if I could say, tobacco is on the agenda thanks to the cancer society and the Non-Smokers' Rights Association. It just dropped in the council's lap. I can say it now because I'm outside council now.

We had a vigorous debate that afternoon and to my deepest satisfaction council passed a resolution to ban tobacco sales in Ontario pharmacies. I could not believe my dream was there. I was thinking if I could ask the college to think about it. Now the council voted to take tobacco out. I could not believe it but it was there.

I was asked, as the president, to strike a task force to find ways to implement this council's decision. It was chaired by a layperson on the council, Ms Jane Chamberlain. I will give you those names because they are significant.

We have asked four people to sit on the task force. I was quite fair in a way that, being president, I would not want to be involved in it. The four members are two members of council, Ms Midge Monaghan from Hamilton and Dean Don Perrier from the faculty of pharmacy. We went outside the council to get two more members, Mr John Connor, an independent pharmacist from the Ottawa area, and Mr Norm Puhl. You may have heard the name already. He's the president of the second-largest chain of pharmacies in Ontario.

1550

Why are those names significant? You will hear all of them in the next few weeks. Ms Chamberlain will be here to speak to the committee; Ms Monaghan is presently the president of the College of Pharmacists. I don't think Dean Perrier will be on the list. Mr Connor will be speaking as the president of the Ontario Pharmacists' Association and I don't think Mr Puhl appears on the list.

Going back to the task force, the task force took almost a year to listen to hearings and read submissions and listen to everybody. We wanted not to make the same mistake as our colleagues in Quebec because over there the College of Pharmacists made a very quick decision to ban tobacco without properly having hearings from the community, meaning all the people involved. So the task force heard over 200 submissions and in June 1991 brought its final report, which council passed after vigorous debate and which forms, ladies and gentlemen, the pharmacy part of this Bill 119.

I speak with emotion because I could never believe it would be here today. When I left council in 1990 for



reasons that people think—it doesn't matter whether I was defeated by a candidate who offered tobacco. I keep on reminding my colleague pharmacists that being a member of the Ontario College of Pharmacists, you are there to represent the public of Ontario; you are not there to represent the pharmacists. So whether I was defeated by my colleague does not matter. The matter for me is for the public health of Ontario.

It took two years for this bill to be here today and I beg you to realize this bill comes from our own governing body, the College of Pharmacists. They will be here in the next few days to talk with you. Would you imagine if for some tragic reasons this pharmacy part of the bill is deleted or lost in the debate? This committee and this government would send a very mixed message to all colleges; ie, on January 1 of this year, with the Regulated Health Professions Act, there are about 23 new health professions and it will send a chilling message to all councils of those colleges that if they send something and ask the government to pass a bill to help the public of Ontario and they get defeated, what is the message that this government and this committee would tell the public of Ontario? Please think of that. That's all I ask of you.

Many of us have spent a lot of time and effort. I have spent a lot of time talking to my two MPPs in our area and I thank you for the time. Publicly I thank Mrs O'Neill and Mr McGuinty for giving me the time to speak to them. They gave me some insight as to how to do it properly and I thank them for that. I would like to take this time to thank the government and all members of this committee, the previous five or six Health ministers who had to deal with this tobacco issue and didn't have a chance to do it.

This is a time that we in Ontario have to present ourselves as leaders. Leadership is difficult sometimes because we have to make difficult decisions. Am I quoting Brian Mulroney? Forget it. Don't say that. Sorry about that; I'm just joking there. The world is looking at Ontario—the small world of other provinces. Many colleges of pharmacy in other provinces told me personally when I was the president that they look at Ontario. If Ontario passes it, they will do it. North America, meaning the US, is looking upon us.

When I visit my fifth-year students in France—I still go there and give some lectures in international jurisprudence and pharmacy as a guest lecturer—we bring up this question of tobacco in Canada. They are amazed that this thing has dragged on so long. But I told them, in Europe, you could be very dogmatic. The college could do things that in Canada we can't because we're supposed to be a democratic country. We let everybody discuss the thing. We cannot go and pass a law. So they are amazed.

My professors, my mentors, keep on telling me: "If you're doing the right things, don't worry about the consequences. Later on, history will tell you that you were doing the right things." I'm asking you, history is looking at Ontario now. Please do the right thing. Pass the bill pertaining to pharmacy as it is.

Pharmacists in Ontario have already had four or five years to get ready, from 1990. If they're not ready by now, they will never get ready. So if they come and beg

you for one year and two years and three years, it's all in the task force, 1991. It gave them two years to get ready. If they haven't got ready by now, they will never get ready, ladies and gentlemen. Thank you.

**Mr Semchism:** Thank you, Nghia. I would like to call on Margaret Frankovich to share her views and experience on removing tobacco from her pharmacy.

**Ms Margaret Frankovich:** I'm here to show my strong support for Bill 119 and to applaud the government for taking a decisive stand on a serious issue. I fully support this legislation, not just as a citizen but also as a pharmacist and a founding member of the group Pharmacists in Support of Bill 119.

I'm a third-generation pharmacist who is an owner of a community pharmacy in Brooklyn, Ontario. I've been an active, practising pharmacist for 22 years, and during this time I've had an opportunity to be exposed to a wide variety of pharmacy practice in Ontario.

I've worked with the Addiction Research Foundation in northeastern Ontario; been president of the Porcupine Pharmacists Association; been on the council of the Ontario College of Pharmacists; worked at the faculty of pharmacy, University of Toronto; and I am presently coordinator of continuing education for the Durham Region Pharmacists Association. I am a pharmacist who is absolutely committed to pharmacy as a health care profession and to pharmacists as members of the health care team.

In the past, perhaps none of us knew the full story of the health risks involved with tobacco use, but during these hearings, this committee will be made very much aware of these risks and the resultant costs to the people of Ontario. Pharmacists are aware of these risks and because of this should not be involved in the promotion or sale of tobacco products. Pharmacies, which are health care facilities, are not suitable sites for tobacco sales.

How can I, as a health care professional committed to pharmaceutical health care and receiving fees from the Ontario Ministry of Health for pharmacy services, be involved in the sale of a product which is known to cause such morbidity and mortality to the people of Ontario? For our pharmacy and our pharmacists, the answer is that we cannot be involved. We have not sold tobacco products since 1983.

During these hearings, you will hear arguments which predict job losses and the economic demise of pharmacies which are forced to give up the sale of tobacco products. Our pharmacy has not sold tobacco products for 10 years and yet we are still a viable pharmacy, and not one person lost their job as a result of this action.

In my opinion, the reason we were able to do this was that after ceasing the sale of tobacco, we were able to focus our attention on health care, which is the primary reason for our existence. It is for these reasons that I have chosen to strongly support this legislation and to urge its enactment. I thank the committee for allowing me the opportunity to present my views.

1600

**The Vice-Chair:** We have time for one short question only. Mr White had indicated he wished to ask a question



some time ago.

**Mr White:** Ms Frankovich, you spoke of your pharmacy's efforts. You stopped selling cigarettes some 10 years ago. Not unlike Mr Truong, you experienced some loss of revenue. Did you experience some loss of revenue as a result?

**Ms Frankovich:** No, I'm going to be appearing before the committee again and when I do so I will be showing my financial statements that show my sales continued to increase. I will also show you my financial statements for 1992.

**Mr White:** So not only did you not lose money as a result of this, you were able to maintain your integrity as a health care professional without ending up in the poor house or your pharmacy closing down.

**Ms Frankovich:** That's correct.

**The Vice-Chair:** Thank you for your presentation. We do appreciate it.

**Mr Jim Wilson:** Mr Chairman, I should caution the witness not to show any profit or the NDP will have her before the finance committee.

**The Vice-Chair:** That's not a permitted comment. Again, thank you for coming forward.

#### ASSOCIATION OF LOCAL OFFICIAL HEALTH AGENCIES

**The Vice-Chair:** The next presentation will be made by representatives of the Association of Local Official Health Agencies. I would ask the representatives to come forward, introduce themselves and proceed with their presentation. Hopefully, there will be questions.

While the representatives are being seated, I will confess to the committee to being a director of this particular association in a former life. Welcome.

**Mr Richard Cantin:** My name is Richard Cantin and I'm a vice-president with the Association of Local Official Health Agencies, ALOHA. I'm also chair of the health committee in Ottawa-Carleton. David Butler-Jones is a medical officer of health for Simcoe county and a member of ALOHA, and a person who originally wasn't planning to be here—she's along for moral support—is our president, Helena Jaczek, who also happens to be the medical officer of health for York region.

ALOHA is the collective voice of Ontario's 42 health units and boards of health. I'm not going to bore you by reading verbatim. That's probably the only thing verbatim I'm going to read in the whole brief.

The Health Protection and Promotion Act defines the mandate and responsibilities for boards of health and medical officers of health in key areas that make a difference to Ontario's health. Ontario's government faces a very difficult issue with Bill 119, that of possible loss in tax revenue due to reduced sales and possible loss of jobs in the tobacco industry proper.

ALOHA wishes to congratulate the government on the introduction of legislation to reduce the number of young people who become addicted to tobacco. Much like one of your past presenters, we feel that with people my age, you may as well give up. Once they're addicted, they're lost. But if you can hit somebody before they're 19, it's

a much easier sell to keep them off.

We have enclosed in the package some recent resolutions from our annual general meetings which touch on the subject and indeed support the government's position.

**Dr David Butler-Jones:** We're not going to repeat the mountains of evidence that really identify tobacco as our number one preventable killer in Ontario, and actually most of the developed world. If we're going to have any real success in challenging this epidemic, then we really have to focus on preventing addiction.

This century has seen some remarkable improvements in health, and in fact, if you look at each day of the century, average life expectancy has increased by about eight hours. Unfortunately, most of that's been wasted in terms of the life expectancy of tobacco smokers, and we really have to get at it early.

In that context, tobacco use prevention is our most important public health problem. Potentially, this legislation that you're dealing with could prove to be the most important piece of health legislation in this decade.

**Mr Cantin:** Evidence will show you that there are 13,000 deaths due to cigarettes in Ontario every year. That's equivalent to having an A300 Airbus scheduled to crash-land at Pearson International Airport every week of the year. That's 52 Airbuses, 13,000 people, passengers and crew.

Therefore, we are supportive of licensing restrictions with stronger measures to prevent sales to minors, the elimination of vending machines, the removal of the anachronism of tobacco sales by pharmacists who profit from ill health caused by tobacco, and these are to be commended.

I'd like to piggyback on a statement made by a pharmacist earlier. I live in a community east of Ottawa called Orleans, and recently a chain of pharmacists from Quebec moved into the neighbourhood. An independent pharmacy hooked on to this chain and invited me to the ribbon cutting, which I refused to attend because as chair of the health committee I could not go to the ribbon cutting of a pharmacy that sold cigarettes. He found that unfortunate, especially when I told him that I would cease to be a customer, because I had been a long-time customer of his. He found that very unfortunate, did back flips and everything to entice me to go, and I refused to go.

The nice thing about this story, the nice ending, is that two months later he called me back. He'd been in intensive negotiations with the president of the chain and for the two months that he had to sell cigarettes they were not visible. They were under the counter. You had to request cigarettes if you were going to have any. The beauty of it is that he called me after two months of intensive negotiations to tell me that he no longer had to sell cigarettes in his store. His profit numbers have gone up from the independent dispensary, to the chain, to the chain without the cigarettes. In fact, he makes a big to-do about the fact that he doesn't have to sell cigarettes, and he doesn't have them. Of course, our local board of health has stickers that say, "This is a smoke-free pharmacy," which kind of reinforces it.

We're told that there's a study about to come out by the tobacco manufacturers that own pharmacies that jobs will be lost; not true. The story you heard earlier is replicated many times over in Ottawa-Carleton. What we like about the legislation is that it hits the root of the problem. It proposes to have some fines for not only the retailers, but people who might be buying to resell to kids, especially in high school. I've got a 14-year-old who was offered cigarettes in his high school. I'd like to see that person hit. So let's make sure that what we do, the decisions that come out and the recommendations that go to the Legislature are those which make it very difficult and very uneasy for the person who does in fact sell to the underaged.

Price and availability are key determinants in acquiring addictions. It's a fact which drives tobacco lobbies to call for reduced taxes. The temptation to accept this quick fix must be challenged. The only outcome of lower taxes will be thousands more addicted teens and premature deaths.

Smuggling of Canadian cigarettes back into Canada should be fought through law enforcement and appropriate distinctive packaging. We've been talking about plain packaging for all companies, not through the surrendering of the next generation. ALOHA also supports a reintroduction of the export tax by the federal government.

We've said it and everybody will tell you that if you can stop someone less than 19 from smoking, you will increase the chance that they will not be a lifetime smoker. We feel that not only should the legal age be up to 19 years to smoke, but for the person who sells the cigarettes it should be 19 years as well.

**Dr Butler-Jones:** Just to elaborate a little bit on plain packaging and health warnings, not very much, basically our request is simple. It's been shown that plain packaging is a disincentive to young, new smokers and yet has little effect on the established smoker.

The other thing is that basically the only thing we want on cigarette packages, other than the basic identification that this is a Rothmans or a cigarette, should be the health warning, and that also will make it much easier to identify cigarettes that originated elsewhere.

1610

**Mr Cantin:** We hear that some pharmacies are crying foul, that they're not being treated the same as retailers. Maybe the pharmacies have to make a decision. Do they want to be pharmacists or health care professionals, or do they want to be retailers? There are enough corner stores that can sell the weed. We don't need to have the pharmacies selling them as well. If the pharmacies really feel they're being dealt a hard blow as retailers, maybe we should go the route of the LCBO-type dispensation; you have to have a very controlled atmosphere in order to sell through that kind of venue.

**Dr Butler-Jones:** The final point we want to raise before the committee is a key public health issue, and that's involuntary smoking. When it comes to smoking in public buildings, we really hope that the government will introduce strong regulations that will limit smoking in public places. It really is essential to avoid dangerous,

secondhand tobacco smoke. Innocent bystanders are particularly the issue here, there's no question.

Just to give you a sense of the day-to-day impact, from time to time I do my turn in an after-hours clinic, and at this time of year with literally half the kids I see, the only reason they are there is because of tobacco smoke in the house. The bottom line for all of this is that the opportunity is now to save the next generation and we must act so that tobacco addiction will die a natural death. Finally, a reference in history, and if I might say, from a personal standpoint: I really don't want a generation from now having to be dealing with the suffering and the pain and the needless cost of inaction today.

**Mr Cantin:** We thank you for your attention. All three of us are available for questions if you have any.

**The Vice-Chair:** Mr McGuinty.

**Mr Jim Wilson:** Are we going in any sort of order here?

**The Vice-Chair:** Yes, I was trying to go in order.

**Mr McGuinty:** Thank you for your presentation. Richard, it's good to see you, and I'll take the opportunity to congratulate you on your involvement in health-related issues. Mr Cantin and I are involved at present in an effort to make CPR mandatory in our Ottawa-Carleton high schools. It's a four-hour course some time in grade 11 or 12 and we're looking forward to some positive results.

**Mrs Haslam:** Have you got flyers?

**Mr McGuinty:** I'll be signing things outside later.

One of the things I wanted to mention was that this issue of plain packaging is interesting. I read about a study that was done in the States where adults were offered Marlboro cigarettes at a substantially reduced price if they were to be sold in a plain package, but they were so hooked on the aura and the mystique as a result of a very expensive and effective advertising campaign that they just had to have that packaging. So I think even so far as adults are concerned, plain packaging would have some impact.

I really don't have a question for you. I thought your brief was good and I appreciated it.

**Mr Jim Wilson:** Thank you very much for your presentation, and it's nice to see Dr David Butler-Jones from our county, Simcoe county. I know that in the time I've been elected and prior to that as an assistant, I've read many of your articles in the local papers and that you've sent to us regarding smoking and other issues, and I just want to say publicly that I think you're doing an excellent job.

Like Mr McGuinty, I agree with most of the brief; in fact, it's one of the few briefs that mentions pharmacies that I think I can agree with—the point of purchase, the point you make on page 3. I'd be interested to know whether anyone has actually seriously pursued this, and that is to restrict the sale of tobacco products in premises like LCBO and Brewers Retail. I would say it would be the ultimate level playing field for all those retailers out there. Frankly, I can see that happening at some point in my lifetime, I expect. If the trend continues and the



public continues to get fed up with smokers, which they clearly are, then we may see it into restricted licensed premises like that.

Has anyone seriously pursued that, that you're aware of?

**Dr Butler-Jones:** In terms of jurisdictions, not that I'm aware of. Obviously, there is the ease where you already have a licensed premise. You have the situation where people under that age aren't able to walk in and purchase. You have ID cards. It fits very neatly.

The thing that we experience, and it's not unique to Simcoe county, is that people walk into pharmacies, kids of 14 and 15, they're unchallenged, they buy a couple of packs of cigarettes and they walk out; no big deal. That's much harder to do in a Brewers Retail.

**Mr Jim Wilson:** That's true.

**Mr Cantin:** It's especially true when the cartons of cigarettes are right there at the cash at the door. If they're on open display, it seems as if there's a blessing by the health care community for cigarettes, that it's really not going to harm you, no matter that commercial with Joan or Joanne, where she huffs and puffs in the bathroom and ends up dying by the end of the 30-second clip. No matter how effective that public service announcement is, if you walk into a pharmacy and you can associate cigarettes with health: "My parents are kidding around. They're not serious. It can't be that bad. We know people who smoked till they were 83." But they don't talk about all the other victims along the way who might have had asthma, who might have had allergies.

I'll tell you a very short but personal story. I was a corporate trainer with Canada Post for many years and didn't drink at all in those days. After a full day—

**Ms Murdock:** But he does now.

**Mr Cantin:** Things have changed. When you become a politician, you take on other things.

The odd thing is that I'd wake up following a training session out of town and I'd have the worst headache, similar to a hangover. I'd come back from my trip, a day back at the office and it was gone, but for the week I was away, I was suffering. My eyes were puffy and I didn't sleep well.

I went to see my GP and he suggested: "Maybe it's your training sessions. Do people smoke in the room?" "Yes." "Well, try one of two things: Have them leave the room during the training session or you're one of these guys who's used to being outside all the time and maybe you could open the window and offer a people the choice, 'We work with the window open or you leave the room if you want to smoke.'" I did the open window thing for a while and never got a hangover all week. So there are people who are affected very tremendously by the effects of secondhand smoke.

**Mr Jim Wilson:** Yes, I know some.

**Mr Wessinger:** I have a question. I'd like to explore your comments with respect to involuntary smoking and the question of smoking in public places. I have two questions, first of all. One is that we had some representation by the restaurant association suggesting that they

could, by certain ventilation measures, protect patrons against secondhand smoke and I'd like your comment on that.

**Dr Butler-Jones:** It is conceivable. For a room this size, though, my understanding from the engineers is that you'd need a fan the size of half that wall to actually ventilate it adequately. You'd need to have segregated dining areas basically with separate air flow, and the same for other buildings. If you have a totally segregated area with a different air source and venting to the outside, that's quite possible. You could have that.

My concern would be how it would be applied. For example, recently at a lunch that I had with a local MPP, the smoking section was about six inches from the non-smoking section, sort of meeting the law but not quite meeting the intent of the law.

**Mr Wessinger:** Just to add, do you have anything we could look at as a guideline in determining where smoking should be restricted in public places? Are there any bylaws you've seen that have been particularly good or as a guide?

**Dr Butler-Jones:** Toronto's is probably the most active in that area. I think what ALOHA in the past has talked about is basically any public space, so you're looking at arenas, at restaurants, office buildings, unless you have a designated smoking area. The focus should not be carving out small areas where non-smokers can go and be protected. It's a matter of providing a separate space for smoking for those who need to do that, or outside.

1620

**Ms Murdock:** I noticed that the last resolution, for the East York Board of Health, was suggesting under one part of the resolution including taxis as covering an area for no smoking, just to follow up on Paul's question.

The question I want to ask is on your plain packaging and health warnings because the OMA made it very clear about calling tobacco a poison. When they said it, and they said it so strongly, I thought to myself, "Gee, it's a wonder it doesn't have the hazardous signage"—

**Dr Butler-Jones:** Skull and crossbones.

**Ms Murdock:** —"that they have under the Health and Safety Act." I was wondering what your views on that were. With respect to plain packaging, the point has already been made, but if you had a skull and crossbones across the front of it, I'm wondering how effective that would be.

**Mr Cantin:** I'd like to draw on personal history again. I've got a father who's about to turn 84 years old. I was playing midget hockey, and Dalton McGuinty will remember and maybe Ms O'Neill will remember, at the old YMCA auditorium in Ottawa. That's where I played, so it was a few years ago. My father couldn't skate the length of that hockey rink when we went for practice.

Today at 83, about to be 84, he skates a length of the Rideau Canal, four and a half miles, and back. He hasn't smoked since the age of 53. He's been without smoke for 30 years and the reason he quit smoking was that one night he went into a coughing fit. This was a man who smoked three decks a day, 75 cigarettes a day. He quit



overnight, he was so afraid to die. That's what it took.

**Dr Butler-Jones:** In terms of the question, I think we'd want to go to the literature more and actually do some market testing. My guess is that actually a skull and crossbones might be more attractive. From the studies I'm aware of, the simplest thing is a very simple message that makes the package look unattractive, but the only thing you see is, "Smoking causes death due to" or whatever, as opposed to a skull and crossbones, which may actually be a cult identity. You'd want to market-test that kind image.

*Interjections.*

**Dr Butler-Jones:** Yes, that's right.

**Ms Murdock:** You mentioned Toronto, but I want to get on the record that Sudbury had a big controversy when it passed its resolution—I'm sure your district health council would probably have advised you of it—where it made all public buildings in the city non-smoking. Even though the university rents out the great hall to weddings and so on, there is absolutely no smoking on the premises.

They did it at the arena as well, and the controversy came over the bar in the arena and whether or not a portion of it could be designated non-smoking. The council voted against smoking being allowed. They said, "No, it will not be allowed." There was a big controversy again. They revisited the issue and voted again and, proudly I guess I can say, they voted that there will be absolutely no smoking anywhere in any of the public buildings in the city.

The rest of the municipalities around the city of Sudbury haven't done that yet, so regionally we aren't covered, but municipally we are. It's slowly coming on a voluntary basis.

**Dr Butler-Jones:** It really is a patchwork and that's the difficulty.

**Ms Murdock:** Yes.

**Dr Butler-Jones:** Places like arenas often are ones that in the past have challenged it the most. I've seen many kids who would wheeze every time they play hockey until you can get the smoke out of the arena.

**Mr O'Connor:** Thank you for appearing before the committee. We're hearing from a group called the Committee of Independent Pharmacists and they've asked municipalities right across the province for endorsement of the bill other than the ban on pharmacies. I just wonder whether you would have been requested—Dr Jacek would perhaps have been approached—by the local municipality for some response in preparing a resolution either yea or nay for this.

I've seen one of my local municipalities that has responded to it. I don't think they approached the pharmacists, because I know of two; one sells and one doesn't. I wonder whether you have been asked for advice by any municipality on whether or not it should be endorsing such a resolution?

**Dr Helena Jacek:** In relation to York region specifically, of course I did receive the resolution and the suggestion that I forward it to our regional chairman, who

also had his own copy. Each of the nine municipalities also have their own copies. You can be sure that unless I'm specifically directed to even popularize this, I would not do so.

The pharmacists' association has spoken very clearly: They are health professionals. It simply, in my view, is entirely inappropriate in terms of what they're circulating to municipalities. I feel fairly confident in our own region that there will be absolutely minimal interest.

One point I'd like to make is simply that the reason why I think Bill 119 is so important and why we are having legislation now is specifically because all the efforts made to date have not been sufficient in terms of the epidemic of new smokers that we're seeing, especially the young female smokers. The public health messages, the municipal bylaws—in our own region we have some excellent municipal bylaws—are still not sufficient. It needs to be a total package such as this particular piece of legislation encompasses, and this is the appropriate way of handling this problem at this time.

**Mr Cantin:** With our region being a border region with Quebec, and our knowledge that Quebecers are just about born with a cigarette in their hands, it's more difficult for one municipality to go ahead. Ottawa has tried to spearhead things. I think they went about it the wrong way. They tried to exclude some of their facilities and include some of the other ones, and you've got to have the same treatment for everyone.

To me, the only way to go is to have a province-wide regulation which touches pharmacies, a province-wide regulation when it comes to sports arenas or stadiums or things like that. You certainly can't have situations like one I'm aware of at the SkyDome, and the SkyDome is a smoke-free situation. There was a health fund-raising organization that had a special event there, and there in fact was a smoking area and the Metro police looked the other way. They were not enforcing their own bylaws. So there's a need to do things the right way.

We in Gloucester—I represent the city of Gloucester at regional council—have taken the approach that if the customer walks into a restaurant and is bothered by the smoke, all he has to do is walk out. Do that a couple of times and the owner will realize what it is. As a result of that, most of the restaurants that I frequent have over 75% of their seats as smoke-free. You're really a second-class citizen if you walk into those restaurants and you're a smoker.

**Dr Butler-Jones:** I'm not sure whether it's been raised yet with the committee, but one of the things I often hear around smoking in restaurants is that business falls. They give examples of the local doughnut shop that went out of business after it went non-smoking. Really, the reality is that's an issue of marketing. The doughnut shops I'm aware of that have gone non-smoking but didn't tell anybody have gone out of business, because the smokers leave but the non-smokers who have quit going to donut shops don't come out, whereas the ones that advertised are bursting at the seams. It's the same with Taco Bell and other restaurants. It's an issue of marketing.

The advantage of making it the same for everybody is

that then it's no longer an issue, and jurisdictions that have done that actually have found more people eating out and going to restaurants, people who had given up going out to restaurants because they can't stand smoke, even with non-smoking sections. It's just too much for them.

**The Vice-Chair:** Thank you very much for your presentation. It's very helpful. We appreciate it.

1630

#### CANADIAN ONCOLOGY SOCIETY

**The Vice-Chair:** The next presentation will be by a representative of the Canadian Oncology Society. Please come forward, introduce yourself and proceed with your presentation.

**Dr Michael Goodyear:** Good afternoon and thank you very much for the opportunity to come and speak to you today, and thank you for your patience for lasting through the day so far.

Congratulations, ladies and gentlemen. You are at a historic moment in the history of public health in Ontario and you have enormous potential to do good today and in the coming days.

I have a sort of sense of déjà vu, because on Wednesday April 19, 1989, I was sitting here in this room addressing the same committee. Reading through my presentation to that committee, I decided it was so good I didn't really need to repeat it again. Maybe the clerk could provide members of the committee with it. We made all the points there and five years later we're here to see whether you're actually prepared to implement them.

Actually, it's interesting to see how many people are still on the committee from then. A few of them seem to have escaped for the day, like Mr Sterling or Dianne Cunningham, but I recognize Yvonne O'Neill over there. I'm very delighted to see Ron Eddy, my next door neighbour. Many of my patients come from his constituency and many of them have discussed the issues with me and I will come to that in more detail in a little while.

I am going to apologize and crave the indulgence of the members since I basically gave up working on this brief at 2:30 this morning. Some of you may have read the Globe and Mail this morning and noticed that a number of us have been rather busy over the last few days. I think, in baseball parlance, we were thrown a curve ball by the tobacco industry a few days ago. Many of us had to drop all the efforts in working on this bill and devote ourselves to this insane rollback of tobacco taxes, which I don't think was coincidental. I think this bill represents a major threat to the tobacco industry and its \$100 million in profits per year.

However, what you actually have in your hands, in terms of a brief, is a bit of a rehash of what was given to Karen Haslam back in March, but it does provide you with some background information. What I will do is just leave a rough draft of my comments this afternoon with the clerk.

I believe I have until the 18th to get a very thorough, carefully documented brief to you. I know how much you love going through clause-by-clause so it will contain

every suggestion in the form of drafted amendments to save you all lots of time and work. A lot of them are technical amendments and we won't take up too much of your time with those today.

What you actually have, or should have, in front of you today should be, if I can find the right document, something called *Stepping Forward*—I've just discovered page 3 is missing but don't worry—and a whole lot of background material.

I believe my secretary actually bound in a separate document and didn't include it—probably because her stapler wasn't big enough—which is actually the most important document. It's one that is a comprehensive strategy. It's a conceptual framework in which you can relate all the things we're discussing. In my brief, I will make numerical references to those points.

Who am I? You're probably going to ask as you've asked a lot of people here today. My mind is taken back again to 1989 when our colleague Richard Allen—I'm sure he'd love to be here today because I know he's spoken passionately on this subject in the House on many occasions but is in a warmer climate in South Africa today—asked me why did I come here today to talk to you. I think what I said then is still valid.

Technically, I'm here representing the Canadian Oncology Society. At the last page of your brief, at the back of that proposed strategy, for some peculiar reason, is a sort of mission statement of the Canadian Oncology Society. Suffice it to say that we represent all cancer specialists in all walks of medicine right across Canada, whether they be involved in radiation or be surgeons or paediatricians or gynaecologists.

In a way, I'm not really representing those. What I'm representing is, I regret to say, thousands of patients I've treated over the last 20 years that I've been practising cancer medicine who, for obvious reasons, cannot be here today but who, in their dying breaths, expressed extreme sadness and anger at a system that allowed them to become addicted to nicotine as children before they could spell either word and which they struggled with through all their lives and they died from.

I'm also here representing their widows, widowers and their children, many of whom have written to me and asked me to do something about it. It usually starts off like, "Why doesn't the government...?" For a long time I said, "Call your local MPP and tell him what you think about it." Then I decided maybe I should do something about it too. That's why I'm here today and that's what the organization I represent—we feel passionately about this subject.

You've heard a lot about jobs today. Here am I trying to put myself out of a job. I should be delighted if I can go and do something more effective if you do your job this month.

This, I'm afraid, is a sort of war. You may have heard expressions like that before. It's a global war. It's one that's coordinated from our side, if you like, by the World Health Organization. On the other side, the enemy is a series of transnational companies that of course will be scrutinizing your every move over the next few weeks.



I don't want you to underestimate what the potential power of Bill 119 is in terms of global health. Everything that is in this bill will be rapidly transmitted to other countries where this war will have to be fought many other times. Of course, all the other provinces in Canada are also watching the deliberations of this committee.

You're not alone. I know politicians like to be congratulated for being leaders and you are leaders in many ways in this bill but, of course, you're in good company because legislation like this is popping up all over the place in Canada. There are committees like this sitting and discussing very similar legislation to this one. As it happens, there was just a recent one in Newfoundland. We can come back to that. There is an enormous momentum out there across the provinces in terms of provincial legislation in terms of tobacco control.

It's rather interesting that we're sitting here discussing this now, 44 years after the first major scientific studies appeared on both sides of the Atlantic linking lung cancer and smoking. I don't want to be sitting here discussing this—well, I probably won't be sitting here discussing this 44 years later, but that's why I'm relying on you to do your job. I'm going to take a quotation from Mr Paul Martin, the Minister of Finance, who was in Toronto the other day and sat down at an economic conference and said, "We're not here to fiddle."

There has been a minimalist approach to this problem for many years and I hope this is going to be your opportunity to actually make a difference. We're not going to achieve any of the goals in this Ontario tobacco strategy if we take a minimalist approach. This is not Band-Aid legislation, this is a chance—and maybe I'm revealing political biases—that the current administration should delight in, in being able to take on one of the most incredible examples of corporate greed and predatory industrial practices in the world and to actually translate that into some social good.

I also congratulate all parties in the House. I've read the Hansard debates and I'm impressed with the civility and teamwork with which all parties are approaching this and, of course, this is a partnership between yourselves and us.

I want you also to keep very closely in mind, and I'm sure you've studied all these documents, the goals of the Ontario tobacco strategy, particularly those due in 1995, which I remind you is only 11 months away, so we really have to get on with this.

Obviously, you will guess from my profession that we are in general support of all the measures in this bill, although we think there are a lot of areas that need considerable strengthening. I apologize to all the people in this room who worked extremely hard on this bill when I say there's a long list of technical amendments, but I'm sure they will bear with us.

I'm not here to tell you about the problem. You've heard quite a bit about the problem here today. You're supposed to know what the problem is as opinion leaders in this country and you're going to be hearing all about it. As I said, I could send you several filing cabinets of papers about the effect that tobacco has on the world. There is quite a bit of information in the background

that was circulated a little bit earlier. I think as politicians you want to hear about solutions, so let's talk about the solutions.

I also know that, as politicians, you're also interested in public opinion. I will be depositing with the clerk a tabulation I prepared of public opinion polls over the last few years which basically show support running for most of the items in Bill 119 at about 80% to 90%. I think that this, despite some of the opposition you've heard from certain quarters, is something that is going to get you a lot of public support.

You're not going to hear from the tobacco industry. I did notice a member of the board of directors of Imasco sitting in the back of the room earlier on in the large crowd. They're not going to appear and argue about the things in this bill, they're too close to motherhood, but you will hear from some of their friends, those people who have become economically dependent on them who will be pushing their particular thoughts.

For Mr Eddy's sake, I noticed in the Hansard reports that there was some discussion about the effects of this legislation on a certain sector of the Ontario economy. In fact, I spent quite a lot of time over the last year working in municipalities along the north shore of Lake Erie, and I actually spent one day with Peter North in his riding, talking to the farmers down there. I don't know if they're wanting to come here, but I will say that, just remember, if you completely stop all tobacco usage in Ontario tonight, you will only shrink the demand for Ontario tobacco by 16%.

We live in a market economy. It is driven by changing needs. Our demand for various consumer products is changing all the time and I think this is an economy that is adapting. There are special economic needs in the area that need to be addressed, just like they do in many other parts of the economy, but I do not think you should stay your hands on this legislation because you think we should be promoting the economy in southwestern Ontario. I think those are two totally separate issues and I think the people down there know that only too well.

#### 1640

The major areas we would want to address really are in the labelling of the product and you've heard something about that today; the regulation of sales and I notice you're very interested in that; and basically the protection of the general public from the combustion products of tobacco.

We've also heard a little phrase that seems to slip off the lips rather easily today about, "This is a legal substance." Actually, rather interestingly, it's not strictly speaking a legal substance. It's very difficult to define what a legal substance is. For your interest, it's actually a controlled product under the meaning of the Hazardous Products Act, a federal piece of legislation which basically classifies toxic substances as either being completely prohibited, which clearly it's not, or as being controlled. In many circumstances tobacco is an illicit drug.

One question that always comes up at these sort of committee meetings is, "Do you think we should prohibit this?" I think in my heart I would say yes to that, but I



think that many of you remember, and we saw a fascinating video about this. We also heard a lot about gun-running and various other irrelevant subjects. We saw the stills of the Prohibition era. We know that an unbalanced strategy, one that merely seeks to block access and supply, is unlikely to work, and we also know the craving for nicotine is even more powerful than it was for alcohol in the time of Prohibition.

With 5.4 million Canadians being regular smokers at the moment, prohibition isn't the answer today. It may come when that number is considerably shrunk by the efforts of yourselves over the next few weeks. We need a somewhat more sophisticated approach to the social change that I believe, from your comments today, you all desire.

However, there are many tobacco products on the market, and I want to draw your attention to one particular one. I think there has been some reference to it today. I'm just going to pull out here a magazine that is widely circulated in Ontario schools. It's called *Sports Illustrated*, and no, it's not the swimsuit edition, about which the least said the better. Here is a full-page spread for Skol. This is smokeless tobacco, chewing tobacco, spitting tobacco, snuff, whatever you call it.

I think you know the sort of kids who read this. This is very much oriented to adolescent males. Many of the athletes pictured in its pages have this sort of peculiar bulge in the side of their cheek, which I'm told is not cancer but tobacco, and I'll return to that.

Mary there and I had the pleasure of visiting a school in Hamilton a few weeks ago. You've seen the advertisements that are on television here and you think maybe we're doing a good job trying to preach to the children of this province about the problems with tobacco.

Basically they said: "Who's telling the truth here? We've got these magazines"—I didn't bring things like *Cosmopolitan* and that along—"American magazines, imported publications, and here are all these glamorous people"—there are plenty of those in here—"all having fun, and they're obviously all having fun, because they're riding horses or they're surfing. They're enjoying themselves because they're smoking, and yet you're telling us that it hoards all these terrible things."

Of course you know this fellow here, don't you, Joe Camel. He's more well known than Mickey Mouse, according to a recent survey of American kids. These children are exposed to a lot of influences from advertising. You thought advertising was banned in Canada, but we allow imported publications.

It's rather interesting that *Sports Illustrated* actually brought out a Canadian edition in November of last year: no tobacco ads in it at all. Unfortunately, due to protests from Canadian publishers, this was then banned by the federal government and we had to go back to getting the American version with all the tobacco ads in it again for the children. Unfortunately, sometimes social policy has undesirable side-effects that one hadn't really thought of. However, in my brief I will address that there is something you can do about that.

The main thrust I'm making here is that while smoke-

less tobacco, spitting tobacco, is increasing at an alarming rate in the United States and is increasing at an alarming rate among native children in Canada, this is one product that I think we can nip in the bud before it gets any worse. Many jurisdictions throughout the world have already prohibited the use of smokeless tobacco.

It's very interesting that this particular ad tells you that this is the one tobacco product you can use where you can't light up. In other words, they see what is happening to our society, that smoking in public places is decreasing, so here is the chance to replace it with another form of tobacco, and we're back where we started again. I would urge you to think about that.

As you well know, advertising and promotion is controlled by federal legislation, the federal hazardous products control act. This is the subject of Supreme Court of Canada hearings that will be going on this year. Preliminary hearings have already taken place. There is the possibility that due to a technicality, that legislation could be struck down as being invalid some time this year.

The tobacco industry has actually spent, through many court cases leading up to the Supreme Court case, years of arguing that this is provincial jurisdiction and not federal jurisdiction. Therefore, it is vitally important that Ontario follow the example of British Columbia and incorporate what is in the federal jurisdiction into the Ontario legislation, because otherwise you might suddenly find overnight, in a few months' time, that it's open season again on Ontario school children and that we can promote and give away free tobacco samples and have billboards. If you put that into the Ontario legislation—the industry can't possibly oppose it when it spent all that money arguing that it is your responsibility—I think we will get a lot further.

If we learn from the experiences of the federal legislation, where there are loopholes that allowed you to see these huge, great billboards for du Maurier and Player's cigarettes and racing cars and tennis, we can get rid of those loopholes—I will explain that in our brief—we can get rid of advertising and we can get rid of the link that associates the product, the packet—you've seen many examples of that today—with the advertising, and break that essential connection.

Which of course brings me to the next subject, which is packaging, and I think you've heard much about that today. There is obviously a spectrum from just having a little health warning on the corner of the packet all the way to what they call generic packaging, which is basically that you go to your Loblaw's and get a packet which would just say "cigarettes" on it. Plain packaging is somewhere in between where the manufacturer would at least be able to put his particular name on it.

We completely endorse that. We know from the market research studies that this turns kids off. We know that a lot of the allure of the product, and there is a background paper on this in your package, is very much the cult. I'm told by school teachers that what is very in at the moment is red. If you have a red packet in your pocket up here, you're in the in crowd. If it was some beige colour, presumably this wouldn't work so well.

What I've heard more about today is actually probably about sales: How are we going to control sales? The way I see it, there are basically three sorts of models that have been looked at or used or discussed or debated throughout this jurisdiction and other jurisdictions. The first is what is called statutory prohibition, which is what you're aiming for here in this legislation. The second you've heard a fair bit about today is called licensing. The third of course is the control board operation. I'm making absolutely no bones about it that our organization is advocating completely unequivocally that tobacco should only be sold through a control board and that it is the only solution that's going to work.

It's very interesting that one of the goals of the strategy is not the reduction of sales to minors, it's the elimination by 1995. Brenda and I have had some interesting discussions whether that actually means one minute past midnight on January 1 or one minute before midnight on December 31. I'm prepared to give her a little leeway, because I know she works very hard on this issue.

Anyway, you're not going to get away with a minimalist approach to this one. You're going to have to be darned sure that you choose an approach that is 100% absolutely foolproof, and that is why our organization is advocating the control board setup.

We don't need a separate tobacco control board. That's a lot of extra administration, bureaucracy and finance. The LCBO, as I understand it, is not in principle opposed to the idea of using its facilities. When I've given a number of talks to police services boards around the community, there's no doubt the chiefs of police have been very much in favour of it. They can't and you can't possibly make this work with the current setup.

Do you actually know how many outlets are out there? You don't. The reason you don't is because we don't have licensing in this province, unlike a number of other provinces.

In Hamilton, if I can share some experience with you, we went for a licensing bylaw. We now know, in a city of 300,000, that there are 700 outlets. We know where they are. We know what sort of store they are. We now can develop some strategies to target those stores, to survey them, to prosecute them, if necessary. We can start to get things under way. Licensing has taken us a long way to understanding the problem, let alone doing something about it.

We've heard a lot about pharmacies today. I'm not going to say much about pharmacies. I think it's a very straightforward problem. We support the pharmacists in this issue. That's one area.

I was talking to Evelyn Gigantes about this when she was Minister of Health and we were discussing Hitchcock's film *The Birds*. I don't know whether you remember the final scene there. Somebody lights a cigarette in a gasoline station and that's basically the end of the birds and the end of a lot of other things too. She said: "You're right. Why on earth did we let people sell tobacco in gasoline stations?" Actually, nobody ever let anybody sell it. It's an unlicensed product in a lot of Ontario.

You may remember in the last century, or probably most of you don't remember in the last century, that tobacco was basically sold in tobacconists' stores, specialty stores. They weren't really places where kids went, let alone purchased. But as cheap cigarettes were mass-produced, they spread through society and we saw the lung cancer rates starting to rise off the floor in men and reaching a peak which we've reached now, and then women now catching up, crossing breast cancer rates this year, as we've also heard, and still heading up.

#### 1650

Of course, if you do allow Ontario to roll back taxes like the federal government, these projections that I've made to the year 2010 are useless. These figures will just go off the roof. But anyway, since cheap cigarettes became widely available, virtually everybody out there is selling them from pharmacies to pizzerias to gasoline stations; you name it. It's an impossible situation to enforce, the police say. They're well-meaning. They're stretched to the limit. They say, for instance, that when school breaks up they can police a few liquor outlets, but as far as the tobacco outlets are concerned, it's a hopeless situation, so I think the control board is really the only solution. Licensing has quite a bit to say for itself and we can address that in more detail in the written brief.

An interesting aspect of the sales of tobacco to minors is the question of possession. It's currently in federal legislation. That federal legislation may go by the board because it's technically repealed by an act that has been assented to but has not been proclaimed.

Reading through the committee proceedings from Newfoundland, there were a lot of people like myself addressing that committee and they were listened to very politely. What really made them sit up was this day when all the children came along to speak to the committee. We've had one child here today. I was fascinated that a lot of the children there said that they thought any legislation that addressed the subject of sales to minors wouldn't work unless it was illegal for a child to possess tobacco.

The federal legislation actually allows anyone to seize the tobacco and to confiscate it, which I guess is making the punishment fit the crime. I've talked to quite a lot of kids in schools in our area and they're all saying the same thing, so I think that's something I'd like to leave with you, as to whether you should allow at least some provision for making possession an offence.

The final area in the short time that we have here this afternoon is the question of environmental tobacco smoke. Some of you may have read a column by myself in the *Globe and Mail* a few weeks ago and some of the correspondence emanating from it. I was actually startled to read in today's *Sun*, in two different places, that the minister yesterday announced legislation that would create a totally smoke-free workplace and public place. I think they misread the legislation, but I'm delighted to see that this is now what the minister's now going to do and I'm sure you'll just simply put it into practice, because that frankly is what we are advocating.

Once again, let me draw your attention to the goals of the Ontario tobacco strategy: a completely smoke-free



workplace and public place by 1995. This legislation isn't going to do that.

We are advocating a 100% smoke-free workplace, which reminds me that back in 1989 we sat here addressing a House of a slightly different political mix, and that's where I made a lot of close friends of the NDP front bench. We discussed at great length, in the House and in committee, the question of smoking in the workplace and I think we were all in agreement about it. I know you politicians have been very busy in the last few years and some haven't quite got around to actually doing all the things you said you were going to do in 1989, so this is your golden chance to actually do this.

I was interested to see a study from the city of Toronto health department the other day. They just surveyed all their workplaces to see how their municipal bylaws were getting on. They now have 88% of workplaces in the city of Toronto 100% completely smoke-free. Unfortunately, for those workplaces that decided to go for the other option, that of having a designated smoking area with separate ventilation under negative pressure to the outside, they found that 54% had got it wrong. They didn't understand the legislation. It was in the wrong place. It wasn't ventilated.

I think that's a very good illustration of why partial solutions don't work. As far as drafting legislation goes, wouldn't you agree that it would be the easiest thing possible to simply create a smoke-free workplace? It's an occupational health and safety issue, it has tremendous public support and those people who work in smoke-free environments have really benefited from them.

The other interesting thing, coming back to the smuggling issue, is that if there's one issue in a tobacco strategy that's going to do something about smuggling, it's something that almost immediately decreases demand.

Studies both in Canada and in other jurisdictions have shown that when you introduce a completely smoke-free workplace, a lot of people make up for it outside, in the car and maybe at home, unfortunately for their children, and that actually the individual's tobacco consumption over a 24-hour period falls by 25%. So you can actually smack a 25% reduction in Ontario tobacco consumption by going for a completely smoke-free workplace. If you also go for a completely smoke-free public place you can probably smack an even bigger reduction in tobacco consumption in Ontario.

You can smuggle as many cigarettes across the St Lawrence River as you like, but if nobody wants them on the other side you're going to be taking them all back again the next day.

I heard a question around here about how you define a public place. Don't look now, but in your package there is model municipal legislation that was presented to the city of Hamilton. In it, it defines "public places." The key thing there is, don't start with a list and start adding on and adding on, "Let's have beauty parlours here and barber shops." Let's have a smoke-free public place. We may need to define for greater clarification. You heard about the reverse onus principle. We have a smoke-free public place and we can define a "public premise" quite easily and I've defined it in that legislation.

Let me try something on you that I tried in 1989 that was very effective that maybe the years have passed by. How many people around here had a home that had urea formaldehyde in it? Nobody? I guess you've all moved houses since then. That afternoon at least half the committee put up their hands, particularly when I said, who had it ripped out? Then the interesting thing is that I asked how many of those people allow people to smoke in their homes. Then I asked how many of those people know that there's more formaldehyde in environmental tobacco smoke than there ever was in urea formaldehyde.

I think I heard reference to asbestos this afternoon. How many people would take your kids out of school if you heard that there was asbestos lagging on the pipes? Yet how many people around here know that asbestos was in the filters that were in the cigarettes for many years?

I think I saw on the agenda that there's going to be a presentation, or has been, from the Ontario Restaurant Association.

**Mr White:** There was.

**Dr Goodyear:** I don't know what they said. I'll be interested to find out. But clearly, worldwide there's a lot of concern in the restaurant association. The American Restaurant Association, which recently did a survey and found that far more people would go to a completely smoke-free restaurant than wouldn't go to it, sent out an advisory to all its members, pointing out that there is an alarming number of cases coming through the courts at the moment, from their employees and from their customers, basically claiming damages to their health from eating in a place where smoking is allowed. Clearly, it's going to be in the restaurateurs' interests to go along with a completely smoke-free public place.

I'm going to stop there basically because I love answering questions. I could go on on this subject, as Larry well knows, for several weeks. I'm coming back later.

**The Vice-Chair:** Good. Are there some questions at this particular time? Mr Wilson, it's your turn to go first if you'd like to.

**Mr Jim Wilson:** I'll notify you when I have a question. Thank you.

**The Vice-Chair:** Someone over here.

**Dr Goodyear:** I told you I was passionate on this subject.

**Mrs Haslam:** I want to cover a couple of other things that you had in your A Provincial Tobacco Control Strategy for Ontario. A couple of them concerned me and I wondered if it could really happen.

One was the production. "A definite date needs to be set for the phasing out of tobacco production in Ontario, and the redirection of those resources currently involved in the production of this drug." You talked about prohibition and the difficulty when we see prohibition doesn't work, and will it work in the elimination of tobacco production in Ontario? I wondered if you had some time lines involved in that.

I had one other question. I'm going to put my two



together because Ms Murdock may have a question. Your "Access by Minors," point 2.6 on page 6 of your brief, indicated that you wanted the age of majority to go from 19 to 21. When we talk about changing norms, we see younger and younger children smoking, and I wonder whether actually raising the age from 19 to 21 would have any effect on that because we're looking at changing norms in a society that's changing. I wonder if you have a comment on those two things.

**Dr Goodyear:** I'll answer the second one first because that's the easier one. The age of majority for alcohol consumption has basically been going up and down in our society. It went down a little while ago from 21 back into the teens, and in a lot of the adjoining jurisdictions, particularly across the border in the United States, for instance, in Michigan, it is 21. Some of you may have seen an article in the paper recently showing that a lot of their kids come over here to get drunk and then go back again and get arrested across the border. There was a disastrous accident involving children and alcohol in Caledonia last year. There was a tremendous burst of public support for raising the alcohol age to 21. There were all sorts of letters to the newspapers.

One of the reasons why the age of 19 was chosen for this legislation and in many other provinces which have raised their ages recently was, of course, that it makes a lot more sense to have a consolidated age of majority for substance abuse. You would have exactly the same proof of age required, the same card. It's very easy to administer and it's sort of logical. I just want people to keep in mind that the two should go up and down together and that if there is a lot of public pressure, as there was last year, for raising the drinking age back again, then it would be logical.

Would it make a difference, Ms Haslam says. I think it would. Obviously, it's a lot easier for a 13-year-old to pretend they're 16 than it is to pretend they're 21, and also we are taking out the top of that curve. I'm sure a number of you have seen how there are a portion of children who eventually will end up as smokers and it rises steeply through the teens, through the high school years and then flattens out. It just gets into that area. That would be a much more complete solution, but I'm not necessarily saying that's something we have to do today.

I would certainly suggest that you make the act say "19 or such greater age as the regulations will prescribe."

As far as the agricultural side goes, obviously the agricultural community has seen this coming for a long time. It's a bit unique in Ontario, where most of the tobacco production now is; most of the other provinces have abandoned this. It has been a self-perpetuating problem. Production actually went up again last year to accommodate all this smuggling. We have progressively and are progressively withdrawing direct financial support, which was keeping the industry going and perpetuating the problem.

There is some support being given to the marketing boards and of course we're peddling this stuff in eastern Europe. As the World Health Organization recently said, the problem with Canada is it's not solving its problem; it's shifting it into somebody else's backyard. That's a point that is taken.

The official position of the Royal College of Physicians and Surgeons of Canada, of which we are an affiliate specialist society, has certainly been that tobacco production should cease in Canada. The bulk of it is actually going outside Canada. It's been rising steadily and now over 50% of the raw tobacco leaf is being exported out of the country. A lot of that is going to Third World countries. It's a problem they don't need and it's a problem about which I get sort of kicked in the ankle under the table when I go to international medical conferences because they say: "You're from Ontario. You're the source of our problem."

Yes, I think we should be trying to diversify the economy down there, and as I said, I spent a lot of time talking to farmers down there about it and I've seen the success that some have. There's no cash crop like tobacco, but I think that has been a pipe dream. It's been a very false sort of economy. I think we do have to progressively phase out tobacco production and use that soil for something else.

**The Vice-Chair:** Thank you for your very helpful presentation.

**Dr Goodyear:** You have my phone number. Call me.

**The Vice-Chair:** The committee stands adjourned until 10 am tomorrow morning.

The committee adjourned at 1703.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
  - Carter, Jenny (Peterborough ND)
  - Cunningham, Dianne (London North/-Nord PC)
  - Hope, Randy R. (Chatham-Kent ND)
- \*Martin, Tony (Sault Ste Marie ND)
- \*McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)
  - Owens, Stephen (Scarborough Centre ND)
  - Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Arnott, Ted (Wellington PC) for Mrs Cunningham  
Haslam, Karen (Perth ND) for Ms Carter  
Murdock, Sharon (Sudbury ND) for Mr Rizzo  
Wessinger, Paul (Simcoe Centre ND) for Mr Hope  
White, Drummond (Durham Centre ND) for Mr Owens

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service  
Gardner, Dr Bob, assistant director, Legislative Research Service

# CONTENTS

Tuesday 1 February 1994

<b>Tobacco Control Act, 1993, Bill 119, Mrs Grier / Loi de 1993 sur la réglementation de l'usage du tabac,</b>	
projet de loi 119, <i>M<sup>me</sup> Grier</i> . . . . .	S-735
Ontario Campaign for Action on Tobacco . . . . .	S-735
Michael Perley, director	
John Ronson, chair	
Canadian Association of Chain Drug Stores . . . . .	S-739
Jim Waters, representative	
Rod Stamler, principal, Lindquist, Avey, Macdonald, Baskerville	
Canadian Cancer Society, Ontario division . . . . .	S-742
Dr Donald Cowan, chairman, joint medical advisory committee	
John Watson, volunteer	
Mabel Fraser, volunteer	
Kelly Fairchild, volunteer	
Ruth Lewkowicz, chair, public issues committee	
Ontario Public Health Association . . . . .	S-746
Jane Underwood, president	
Peter Elson, executive director	
Ontario Discount Drug Association . . . . .	S-749
Zel Goldstein, representative	
Marvyn Lubek, representative	
Ontario Medical Association . . . . .	S-753
Dr Tom Dickson, president	
Dr Verna Mai, chair, public health committee	
Dr Ted Boadway, director, health policy department	
Society of Independent Community Pharmacists of Ontario . . . . .	S-757
Jerry Taciuk, chief executive officer	
Pharmacists in Support of Bill 119 . . . . .	S-761
Jim Semchism, co-chair	
Nghia Truong, co-chair	
Margaret Frankovich, founding member	
Association of Local Official Health Agencies . . . . .	S-765
Richard Cantin, vice-president	
Dr David Butler-Jones, member	
Dr Helena Jaczek, president	
Canadian Oncology Society . . . . .	S-769
Dr Michael Goodyear, spokesperson on tobacco and health	





S-31

S-31

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 2 February 1994

# Journal des débats (Hansard)

Mercredi 2 février 1994

## Standing committee on social development

Tobacco Control Act, 1993

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 2 February 1994

The committee met at 1004 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

## ONTARIO LUNG ASSOCIATION

**The Vice-Chair (Mr Ron Eddy):** Good morning. The committee is holding hearings on Bill 119. The first presentation will be by the Ontario Lung Association. Please introduce yourselves and proceed with your presentation. Hopefully, there will be time for a few questions. Good morning and welcome.

**Ms Mary Campbell:** As the vice-chairman has said, we represent the lung association. I'm Mary Campbell, the president-elect of the association. I'm the mother of two young men 16 and 21 years old who, I'm very thankful, are non-smokers. I'm also a teacher at the secondary level and so I see a lot of young people who are addicted to tobacco. It's of grave concern to me.

With me are two representatives of our medical sections, Dr Peter Webster from the Ontario Thoracic Society, and Mrs Cathy Birks from the Ontario Respiratory Care Society.

We'd like to thank the committee for giving us the opportunity to make this presentation and we certainly want to offer sincere congratulations to all, whether they be government members or others, who are responsible for bringing this legislation forward. We offer special congratulations to the Minister of Health and to two members of this committee, Karen Haslam and Larry O'Connor.

We're given to understand that some members of the committee do not support all aspects of Bill 119. We feel this is very unfortunate and we hope we can help to win over those of you who are not in full support of it. We are all for it and we're going to tell you why this morning.

I'd like you all to try and take a deep breath. Anybody have problems with that? People who have respiratory problems can't do that, and that's what the lung association is about. We're about helping people with respiratory problems breathe more easily, and we also feel our mandate is to improve the respiratory health of all people in Ontario. We do this through community programs and medical research that is funded by individual and corporate donations and administered by 33 offices throughout the province. This has been our work since 1904. We are the oldest not-for-profit health organization in the country.

In the old days the problem was tuberculosis. Now it's the tobacco epidemic. As the Minister of Health has said,

tobacco kills one person in Ontario every 40 minutes. That means that before the second group of presenters leaves here this morning, someone will have died from tobacco. We all know that tobacco is the single greatest preventable cause of death in Canada.

Therefore, legislation is necessary, and this legislation is vital to control such a serious health problem. We also all know that no one wants our young people to start smoking. We think that's really where the focus of all the discussion has to be.

I was lucky enough to attend the First National Conference on Tobacco or Health in October. It's interesting that was the formulation: tobacco or health. This is a vital message we have to convey to young people, that it's tobacco or health. That's why it's so important that we end the sale of tobacco in health care facilities and pharmacies.

Dr Webster and Mrs Birks will now present further arguments and evidence for putting an end to hypocrisy in the health community.

**Dr Peter Webster:** I'm Dr Peter Webster. I work at Sunnybrook. I'm the head of the respiratory division there. I'm here because Michael Hutcheon asked me to do so. He's the president of the Ontario Thoracic Society.

You have a written submission of what I had to say. I was told we were talking for about five minutes, so I would rather leave time to answer the questions that are in your hearts rather than the questions that are on my mind.

I don't think there's anyone sitting around this little square who is not aware of tobacco's lethal properties in terms of airway disease. What we seem to have a harder time convincing people of is its addictive properties. This is something that I think is self-serving on the part of the tobacco industry. Reading the history of how the tobacco industry has managed to get the population addicted to tobacco in a large way is an exercise in cynicism beyond belief.

They gave away cigarettes free to the soldiers in the First World War and they spent the Roaring Twenties convincing the ladies to smoke. The most gross of them was that the Lucky Strike company had a problem with green packages—nobody wanted to wear green—so they paid off the New York fashion industry to have a green year so Lucky Strike could sell its tobacco. We're talking about a level of cynicism that's beyond belief, a level of cynicism that's funded by simple pecuniary gain. I'm taking time out from bronchoscoping people to find their cancers. I have half of my ward filled with people who can't walk to the bathroom and back without gasping for air.

1010

We come to this committee understanding that the tobacco industry is insisting on undermining the ethical principles of the pharmacies by forcing ethical pharma-



cists to sell something that they, as a legislated health profession, have decided is unethical. I don't know about you guys, but that doesn't seem right.

If we were dealing with a social habit that managed to get in under the wire because we weren't standing up in defense, I could see that we'd have a problem, but we're dealing here—one thing that I understand is under question in this committee is sale of tobacco in pharmacies—with a legislated health care profession that is regulated by the government, whose regulation is organized through a college properly and duly under legislative control, and that this legislative body of professionals has determined that selling cigarettes is wrong.

We have within that profession some people whose livelihood is entirely dependent on a tobacco company. As a government that has dedicated itself to the freedom and good health of all the province, it would be unconscionable to drop it from this legislation, which has taken several very good steps—not as many as many of us would like to see, but several very good steps—towards reducing tobacco addiction.

The New Democratic Party has long been associated with liberal thought, even if you're not Liberals, and liberal thought insists on a person's independence, on your will, but we're talking of an addiction to a chemical that has a direct access to your will. You cannot talk about free will in somebody you've got hooked on heroin. You cannot talk about having free will in somebody who's been conned into using coke. Take a laboratory rat and give him a training program to learn to like coke and he will like nicotine as well, if not better.

You may have detected that I have a little bit of strong feelings on that one issue. I think the ministry and the government cannot help but say the same thing.

The other issues in the bill are really things we've been begging for for a long time, such as not having tobacco available in your corner store, or plug in a few dollars and you've got your tobacco. There's absolutely no way you can keep the kids out of it that way. We certainly would have liked to have seen a little more control in terms of displays. You go into a grocery store or any store where they're out on the shelf and you know the kids will be going at them. My wife was just telling me yesterday that the gossip in east-end Toronto is that kids from her public school are being sold cigarettes one at a time, as a way of making it easy for them to get them.

Unless the committee understands the level of cynicism in the people who are willing to make their living out of killing people, I don't think you can look reasonably at the arguments around the table, if indeed there are any of the good folk around this table who are arguing that we should make tobacco available to our children.

**Mrs Cathy Birks:** I'd like to thank everyone for this opportunity to come here on behalf of the Ontario Respiratory Care Society. I am a licensed physiotherapist. The Ontario Respiratory Care Society represents a number of various health care disciplines. There are nurses, pharmacists, respiratory therapists, occupational therapists, social workers; there are a number of health care professionals in this organization.

ORCS has taken a very strong stand regarding tobacco and tobacco issues and has put a lot of energy this year towards supporting this legislation. I am here today to again speak for ORCS in saying how important the Tobacco Control Act is. It's very important that we increase our control of tobacco and decrease the accessibility to our youth.

As a physiotherapist, I've spent a lot of time at West Park Hospital on a respiratory program and have worked on an ongoing basis with people who have very severe respiratory disease. Just about all of them have had significant smoking histories. They are very despairing when I talk to them about what's happening and they see young people starting to smoke, because we do know the facts now and the youth of today are being educated, yet they still start smoking. They feel very strongly that we should and have to do all we can to restrict access to tobacco for our youth.

It's very interesting, because in preparing for this and thinking all this through, when I was in high school and in junior high school, I remember very specifically in health class that I had sessions on tobacco, on how much it was going to cost, on what the health care effects were and on why not to start smoking. I was an athlete in many sports and I was a very strong student. I didn't start at the time of my friends and I resisted peer pressure, but there was a period in high school where I actually smoked, not for a long time; I decided it wasn't for me and I was going to stop. Even though I smoked very little and for probably less than six months, it was hard to stop. I found that I missed it in such a short period of time.

We talk about education. I don't think that's enough. We really have to take a firmer hand in controlling it.

Also, now I have asthma and it's very much aggravated by cigarette smoke. It's very important that people are protected from smoke.

I just want to share with you something that was in the Toronto Star this morning. Normally, in the obituaries you see in lieu of flowers people make reference to making donations to various charitable organizations. There's a gentleman who passed away this week and in his obituary it reads, "In memory of Roger, please give careful consideration to quitting smoking one day at a time, as all his doctors have said that secondhand smoke shortened his life." People are suffering and they're dying. This gentleman was only 54 years old. That's very young, in my books. I think there are a lot of premature deaths and a lot of other morbidity caused directly from tobacco use.

As a physiotherapist, I don't just assess and treat people with lung problems; I look at the whole body. As such, I treat musculoskeletal problems. We look at the cardiovascular system and the circulatory system. Cigarette smoking has such a dramatic impact, and at West Park Hospital we treat many conditions. We have a neurology unit and an amputee unit in addition to a vast respiratory program. Through my rotating experience at that hospital, I've seen so much suffering. The most frustrating part is that a large part of the suffering and the deaths that I've experienced could have been prevented

or at least been not as severe, had these people known of the dangers of smoking and not started smoking or cut back on smoking when it was soon enough to reverse some of those negative effects.

In your package, I want to refer to this picture. I didn't choose this picture, but actually when I saw it, it was most appropriate. This man's name is Stan and I worked with Stan at West Park Hospital on a number of his admissions, back in the day when he had pretty good exercise tolerance for exercise programs. We built him up so that he could do several laps of our unit in a six-minute walk test. But I also watched, over a four-year period, significant deterioration in this man.

The last sessions I worked with him, he was so debilitated from his disease that he could barely get out of his chair to go to the washroom, not only because he was so short of breath but because he was in such pain because of osteoporosis. Most of his vertebrae and ribs had fractures. I even felt with my own hands how with a simple cough, the simple effort to cough, which was an incredible effort in itself, this man cracked a rib. This is his daily existence. This is the kind of suffering caused by tobacco products. It's very important that we try to cut back and prevent the youth of today from this same kind of suffering and agony.

The other thing is the cost of this. The health care community is under such pressure with cost containment and yet we are allowing and not regulating enough the sale of a product that costs the Ontario health care system so dearly. When we talk about economics, we really have to address this issue.

#### 1020

As a representative of the Ontario Respiratory Care Society, I mentioned that we represent pharmacists. I spoke in the last 10 days to pharmacists from London, Tillsonburg, as far north as Sudbury, east to Kingston and some in Toronto. I left messages and those I couldn't reach called me back.

These pharmacists are very much in support of the anti-smoking campaign. They are very aware of the issues. They all acknowledge receiving a wealth of information from their college, long before this tobacco act came in. They know their college has been advocating this for a long time, and they spoke very much in support of what we are doing here today, in support of the Tobacco Control Act.

There were a couple of people I didn't reach and I just heard back from them in the last couple of days. Their answers were even more emphatic. The pharmacists who are represented by ORCS feel very strongly that we do need to regulate and that it is inconsistent for a health care professional whose interest is providing health care to individuals in our communities to profit from a product that in fact causes health care problems. These pharmacists agreed with those concerns.

I would like to point out a similar analogy. As a physiotherapist, if I worked in a community setting with an orthopaedics practice, it would be equally inconsistent for me to endorse or promote the sale of a product that I knew was inadequate, for instance, a piece of fitness

equipment that could result in musculoskeletal injuries because it was poorly designed. I could make a good profit on it because it was produced cheaply, yet that could then contribute to my clientele base because these people would have to come for treatment for musculoskeletal problems. I think there's a comparison there. It would be inconsistent or unethical behaviour as a licensed health care professional to profit from that kind of activity.

One last point is that there is a lot of concern about economics. I've heard arguments that there are certain assumptions when you go into a business. You anticipate sales of certain products and then they're taken out from under you. As a health care professional who works in a hospital setting, a year or two ago—I have a house, my mortgage and a lot of expenses—I never dreamed of the social contract or that I would have my salary rolled back and that I'd have to take days off without pay. But as health care professionals we all take responsibility in reducing the costs of health care and rallying together as health care professionals to ensure good health for all the people of Ontario.

In closing, on behalf of the Ontario Lung Association, the Ontario Thoracic Society and ORCS, it's imperative that you consider all the aspects of this legislation. It's very important and we really need to address these issues.

**Ms Sharon Murdock (Sudbury):** Thank you for coming this morning. I'm always impressed at committee hearings that people, particularly in the health care field, who are generally working hard every day, take time out to come and make presentations. It just demonstrates even more clearly how important an issue it is.

On page 4 of your presentation you say: "We strongly endorse raising the legal age for buying tobacco products to 19, the improved packaging and placarding of the health hazards, the prohibition of vending machines, the appointment of inspectors and progressive penalties for repeat offenders."

I want you to comment on that, but I also want to tell you that in my riding—I was speaking to my constituency assistant last night; I'm from Sudbury—my constituency assistant was telling me that the Lucky Strike days are not over, because there's a survey going on for extinguishable cigarettes.

I don't know whether it's happening elsewhere, but it's happening around the university in Sudbury, which is a telling point. There are 10 cigarettes in one half of the package, and in the other half of the package is an extinguisher. It's a twistable filter so that you can make your smokes last longer. That's the sales pitch. You smoke half of it and then you stick it in the side of the package, she was explaining to me, and you twist it off so you can save the other half of the cigarette for later.

If you fill out the survey form, they are giving them a carton of cigarettes as a thank you. So those days are not gone, and the 10-cigarette idea too for the poor pockets of university students is very appealing, so it's not just kids.

**Dr Webster:** Kiddie packs are what I was referring to. A university student is one thing; it's kids in public



school we're talking about. They take it up at 11 and 12.

The extinguishable cigarettes go back to a little story from a violinist friend, the previous conductor of the Boston Symphony, when he was playing the piano for my old friend. He used to have a little pair of scissors and he would cut off the end of his ash so that he could put it away. Saving the last drop is one thing, but having the last drop in an ashtray where the kids come by and pull it out and smoke it is another thing. If the people who can afford it cut off their ash so they don't make a mess and then they leave the thing around, kids are going to pick it up.

**Ms Murdock:** There has been some talk about not liking 19 as the cut-off age. I know you didn't mention it, but what comments do you have to make on that?

**Dr Webster:** That's a social issue. When does one become old enough to make a fool of himself? I don't know. You're the social experts, I'm not. I'd like to see it as hard as possible to get hold of cigarettes. You know as well as I do that raising the price has been the most effective way to get people to stop smoking. The limit on raising price has always been the fear of contraband. If you've been listening to what's going on in Quebec, where all the people who want to sell cigarettes legitimately are up in arms because so much contraband is coming in that they can't sell them legitimately, there's no question that this is a difficult social problem.

We have let loose in our society people who are willing to make money at the expense of others. We're only a Legislature here, and these folks can only write laws. You can't change people's hearts. We try advertising, and you guys have tried with an advertising campaign and we're really pleased to see that, but what legislative authority you have should be used in a healthy fashion.

**Ms Campbell:** I wonder if I could ask Ms Murdock to clarify. When you said there was a question about the age of 19, do you mean that maybe some people would like to have it higher, that they should be 25 or 40? Would I ever love to be refused permission to buy something because of my age?

**Ms Murdock:** I think it was the OMA that was here yesterday—I can't remember which particular group—that was talking about 21, but 19 being the age of majority where you'd have to have a card and so on. Then some people are arguing that you can't do that.

**Ms Campbell:** If we had our way, we would like to see tobacco not available at all for sale to anyone, anywhere, but that's not happening right at the moment and is not likely to happen in the next little while.

It is difficult too that we have so many ages for things for young people between 16—well, even from 14. You can babysit at a certain age, you can be left at home at a certain age, you can be left in charge of other children at a particular age, you can drive at one age, you can drink at another age, you can vote, so it's a very difficult thing to say. I think the higher the age, the better.

**Ms Murdock:** One of the presentations yesterday was that if you could stop someone from smoking by the age of 20, 20 would seem to be the levelling-off age, that

after that they generally wouldn't start.

**Ms Campbell:** Yes, there is evidence to support that, that if a person has not started smoking by the age of 20, they are very unlikely to start.

1030

**Mr Dalton McGuinty (Ottawa South):** I want to thank all three of you for your presentation and for reinforcing—it's funny; you wonder if it still needs to be reinforced but obviously it does—the significant degree to which tobacco has caused harm to our population. One of you spoke about the inconsistency of pharmacists selling tobacco. I don't think there's any doubt there is an inconsistency there, but I think government has to share some of that blame too.

We generate one heck of a number of dollars here through tax revenue based on people smoking. We have allowed, we have encouraged, we have promoted, either explicitly or implicitly, the development of a tobacco industry in this province over the years. We have allowed people to get jobs there. People feed their families there and send their kids to school there. We've developed all of this. The problem of course is dismantling this.

What is your vision? How are we going to eliminate tobacco from the province of Ontario without putting walls up around this province and in spite of all the pressures that take place, both internally and externally? When will it happen?

**Dr Webster:** Inch by inch. As I said in my written deposition, ideally everyone would be reasonable, but the facts of life are that we've got a lot of people out there who are hooked on the stuff. We have to use our wisdom to get it controlled as best we can. We aren't the old Soviet Union, no question, but the thing that I understood to be at question here—if you read the laws, they're sometimes just as bad.

If we can't, as a Legislature, protect a legislated, regulated health care profession from being forced to do an unethical act by a company that is deep into tobacco, I think we've got a little problem with moral backbone. That's all. The only reason I say that is that my gossip was that you were considering dropping the pharmacy thing. Everything else we're happy with.

**Mr McGuinty:** I have raised that question, as you may be aware, time and time again. I would be more than pleased if the government members were to recognize that we are going to be putting some people out of work. There's a cost associated with this, and maybe a large number. I just would like that recognized. We'll be hearing from the next presenters in that regard. I would just like them to stand up and say: "Yes, we're putting people out of work. We're prepared to recognize that. But we think in the grand scheme of things it's worth it."

**Ms Campbell:** I wonder if I could just address the question of vision. I mentioned in my introduction, and I'd like to come back to it, that the key as far as we're concerned is young people. If we can get to the point where we have a generation of non-smokers, which is what we've been working for, then eventually tobacco will be a non-issue.

The times they are a-changing, as Bob Dylan said; not



as fast as we would like, but things are changing. Markets change. People learn to cope. I've just come back from a month in New Zealand. I'm sure you all know the tremendous economic difficulties they had, and yet I did not see a country falling apart. I know they have problems, but what people said to me over and over again, particularly about the farmers who had been heavily subsidized and now are not, was that there is no one who can farm more efficiently than a New Zealand farmer.

People learn to cope. People learn to adapt. But I can't reinforce too strongly this whole idea that if we can keep young people from starting to smoke, then we can eliminate the whole problem and our society and our economy will change in the process.

**Mr Jim Wilson (Simcoe West):** I wasn't planning on asking you a question until you talked about morality. I have a degree in political science and one in theology. I spent five years studying moral and ethical questions, so I always appreciate how the words are used.

As you know, both opposition parties and the government are united on almost all aspects of this bill except the pharmacy provision. As a legislator, am I not morally obligated to try and keep the people of this province employed? Is it not morally and ethically wrong, in face of the fact that I don't have any proof that banning the sale of tobacco products in pharmacies will in any way decrease consumption? If I have no proof of that, other than hearsay and anecdotal evidence, should I allow a section of a piece of legislation to pass that may put people out of work? The same health professionals who talk about smoking also have an obligation, and rightly so, to talk about the pitfalls of unemployment. If the moral and ethical thing is to be used on pharmacists, then we have to apply the same principles across the board.

**Dr Webster:** No, we're not putting the moral and ethical things on pharmacists. What we're trying to do is protect an ethical, organized health care profession which acts in the interests of the people, under legislative control, and which is being forced, against its will and against its stated ethical principles, by a company that is making money out of tobacco. You guys can't continue to run a ministry if you're making money out of what the ministry is doing.

We're talking simple stuff there. We're not talking deep moral problems. We're saying: Is this Legislative Assembly empowered to control the health care professions? Are you responsible for controlling the health care professions? The health care professions have a body that is duly operating under law and has said it is wrong for pharmacists to sell cigarettes, but its own members are being forced to sell cigarettes by somebody who has clearly a painfully obvious interest in selling cigarettes. That's simple.

**Mr Jim Wilson:** I don't think they're being forced—

**Dr Webster:** Name one Shoppers Drug Mart where the pharmacist can say, "I will not sell cigarettes."

**Mr Jim Wilson:** Let's take other pharmacists, though, independent pharmacists. I don't think they're being forced by big tobacco companies any more than the rest of the entire retail market is being forced. All they're

saying is that you must recognize the retailers.

Even the Ontario College of Pharmacists appeared here on November 29 saying: "We want a definition of the term 'patient' in the sexual abuse bill because we don't consider everyone who walks into our store a patient. We only consider that when there's contact between the customer and the actual pharmacist, not the clerk or something, that's when a patient relationship occurs." Of course, we got into the whole debate on whether they could date that patient, but they certainly felt it was okay to date the customer who came in to buy cigarettes and gum and that, because they realized they were a retail customer, not a patient in the health care sense.

Having been through that argument with the board, I find it inconsistent to now come and say, "Look, the entire thing is a health facility and we should ban the sale of a legal product in the entire store," even if that may be a Zellers store with a pharmacy at the back and the rest of it selling clothes and everything else that Zellers sells.

**Mrs Birks:** I just want to briefly respond to the question about jobs and the issues there. As a health care professional in one of many different disciplines in ORCS, a number of our members actually have lost their jobs over the last couple of years and had to seek new employment, look at their resources, because of various changes, be it cutbacks, social contract, the redirection of long-term care.

There are a lot of changes, a lot of dynamic processes in health care right now and they're affecting a lot of health care professionals who are having to deal with that, having to reassess their skills, the different markets they can be in, in order to make a living. I think the issue spans many different groups, not just the pharmacists and the tobacco issue.

**Mr Larry O'Connor (Durham-York):** One very brief question, Ms Birks, because you said you talked to a lot of pharmacists. Did any of them come to you and say, "I'm going to go out of business because of this legislation," or did any of them say, "I've been approached by"—maybe one of the organizations like the Committee for Independent Pharmacists, which will be coming before us later on—and say, "These people represent my view," or did you hear anything to the contrary?

**Mrs Birks:** No. The people I spoke to, these pharmacists, are all members of the Ontario Respiratory Care Society. Please understand that these are people who are volunteers, who have paid a fee to help promote respiratory health in Ontario. These people are all pharmacists who are very committed to this. No, none of them had been approached. As I said, we're in support of this legislation.

**Mr O'Connor:** Going out of business?

**Mrs Birks:** No. Most of these individuals are employed in hospital facilities.

**The Vice-Chair:** Thank you for your presentation. We've run out of time.

**Mr Ted Arnott (Wellington):** Mr Chairman, I have a brief question for the parliamentary assistant pertinent to the committee's work with respect to a study they were talking about on CBC Radio this morning, a British

study that was done to determine the link between smoking among pregnant mothers and, actually, their grandchildren. I wonder if the parliamentary assistant knows anything about it and perhaps he can instruct our researcher to give us some information on it.

**Mr O'Connor:** The study that was referred to this morning will certainly be of interest to all the committee members. I would instruct legislative research if it could take a look into that and provide that or a synopsis of the report so that we can use that in our deliberations, because I think it would be most useful. Thanks for the question.

**The Vice-Chair:** I would also advise that staff has obtained and circulated to you copies of the United States EPA report on environmental tobacco smoke that was referred to yesterday.

1040

#### COMMITTEE OF INDEPENDENT PHARMACISTS

**Mr Larry Rosen:** My name is Larry Rosen and I am a past president of the Ontario Pharmacists' Association. I'm currently a practising independent community pharmacist. I'm involved in the operation of five pharmacies in west Metro, Etobicoke and Mississauga.

Together with my colleagues here today, Mr Aldo Anzil who operates the Courtesy Drug Mart in Clarkson, and Mr Bernie Ceifets who operates—they are both the owners—York Pharmacy on Jane Street in Toronto, the three of us were instrumental in forming the Committee of Independent Pharmacists in response to the adoption by the Ontario College of Pharmacists council on October 13, 1990, of a policy calling for the elimination of tobacco products from pharmacies.

We felt it necessary to start our committee because there had not been any prior discussion from college council members on this issue with the practitioners. I'm talking about community-based practitioners. I'm not talking about the hospital practitioners the lady from the lung association was referring to. I'm talking about the community-based practitioner, the practitioners most of you meet day to day, face to face.

Since then, we have communicated by way of letters and telephone with the approximately 1,400 community pharmacy owners in Ontario who sell tobacco products. Appendix A of our submission contains a fuller history of our committee, which I'll leave for your perusal.

For our submission and presentation today, the Committee of Independent Pharmacists commissioned the firm of Coopers and Lybrand to carry out a study to examine the economic impact of the provision in Bill 119 which would prohibit the sale of tobacco in pharmacies. A summary of the results of that study constitutes a major part of our comments this morning, as well as our submission. The full study forms an appendix to our submission, which you will have.

Our committee and the pharmacists we represent are opposed to the banning of the sale of tobacco in pharmacies. We wish to emphasize that our position and our comments are the result of our conversations, communications and networking with our colleagues across the province, as well as being predicated on the Coopers and

Lybrand study. We want to make it very clear that as pharmacists and as health care providers, we believe we do have a responsibility to deal in a professionally responsible way with the issue of tobacco use in society today. We believe pharmacists should be working constructively and meaningfully towards the long-term goal of eliminating tobacco consumption.

We support the objectives of the government of Ontario as reflected in the Tobacco Control Act and want to participate with the provincial government in helping to curb tobacco use. However, we believe that eliminating the sale of tobacco from pharmacies would have no effect whatsoever on tobacco consumption in this province.

As the Coopers and Lybrand study illustrates, prohibiting pharmacies from selling tobacco will have a seriously negative economic impact. People will lose jobs. Pharmacies will have to restrict their hours of operation and perhaps curtail some of the services they presently offer. Some pharmacies may very well go out of business. Governments will lose tax revenue as a result of reduced revenue of pharmacies.

I would now like to introduce Mr William Rutsey of Coopers and Lybrand, who is here to present the material from the study his firm carried out for us on commission.

**Mr William Rutsey:** I'm Bill Rutsey. We're here to present our analysis. In order that it be user-friendly to the government, we enlisted the services of Dr Atif Kubursi from McMaster University, who has developed the regional impact model used widely by various Ontario government departments. Inputs for the model were developed from both existing information and new data. Based on the analysis performed, we estimate that approximately 2,700 jobs may be lost and more than 100 pharmacies may close. These jobs will not be replaced in the economy and taxes of \$165 million annually will be forgone.

I'd like to introduce Eric Leonard from our retail consulting group, who will lead you through the input-gathering process. Following Eric, Dr Kubursi will explain the outputs, after which time we will be more than happy to answer any questions you might have.

**Mr Eric Leonard:** To determine the economic impacts that Bill has just mentioned, as well as the other economic impacts that are documented in our study, we collected data and information from numerous sources. These include Statistics Canada, the Eli Lilly annual survey of community pharmacists in Canada, and we conducted interviews with independent and chain pharmacies. We requested and received information from various organizations and government departments, including the Ministry of Health, the Ministry of Revenue and the Ontario College of Pharmacists.

In addition, we also undertook our own empirical research. This took the form of a survey of independent pharmacists, as well as the study of tobacco companion sales in Ontario. The result of our research and investigations was a comprehensive, statistical understanding of pharmacy in Ontario.

I'd like to explain our study of tobacco companion sales, which was a component of our overall report.



Tobacco companion sales are products sold to customers at the same time as tobacco is purchased; for example, a chocolate bar and a tube of toothpaste bought at the same time as a package of cigarettes. To estimate the level of companion sales, we collected over 3,300 tobacco sales receipts from 12 independent pharmacies across Ontario. From these receipts, we determined that approximately 39 cents was spent on companion products for every \$1 of tobacco purchased.

On top of this, we also obtained the results of a survey conducted by a chain pharmacy on this same issue. The results of their survey of 32 stores indicated that tobacco companion sales were approximately 38%. Based on these two sources, we've used a conservative estimate of 37.5% tobacco companion sales in our report.

The reason we've done this is that if you prohibit tobacco sales from pharmacies, pharmacies would not only lose the tobacco sales volume, but they would also lose a portion of these companion sales. Using the results of our research as inputs to the province's regional impact model, we looked at various scenarios, including the loss of 75% of these companion sales and the loss of 25% of these companion sales. The pharmacy job-loss figure that Bill quoted to you of approximately 2,746 full-time and part-time jobs is based on a conservative scenario of 25% of companion sales.

I'd now like to ask Dr Kubursi to explain in a little more detail the impact model we used in our report.

**Dr Atif Kubursi:** The point of departure of the study is that ultimately pharmacies are business concerns. They have to meet the payroll, cover the cost and return a profit to their owners. Their ability to adjust their cost to their revenues depends on time.

Economists make a useful distinction between the short term and the long term. In the short term, this is a period short enough that it's not possible for operators to adjust the scale of their operations. They can't adjust their sales and their revenues in tandem. In the short run, there are certain fixed costs they have to meet, and therefore the impact of any particular loss in sales on their operations would depend on their ability to adjust their costs.

#### 1050

In the short run, being unable to adjust fully their cost to their expenditures, they will adjust only that proportion of their expenditures, their costs that they're able to, and this happens to be labour costs. In the short run, we were able to trace the impact of this on pharmacies and then on the economy at large.

The basic model is an input-output model. It's one that portrays the economy as a complex network of interacting sectors. It's an accounting system. It's one that is published regularly by Statistics Canada. It's premised on three basic assumptions:

(1) The initial impacts are a poor estimate of the full impact, that because the economy is an interacting network of sectors, any particular decline in activity in any one component part tends to circulate and recirculate within the economy, magnifying the impact in the economy from the original cuts.

(2) Different activities involve the use of different

scarce resources, and in this respect you cannot generalize from one sector to the other. Each and every sector is a unique activity in the economy.

(3) Impact analysis is the closest time an economist becomes an alchemist, in the sense that there is a chance here of talking about creation of something out of nothing. In this respect, it's very important to outline that these impacts are very much dependent on the level of economic activity and on the underlying assumptions about how the economy operates. If you have an economy that's fully employed and fully flexible, any particular change in any one sector would likely be made up and compensated for in other sectors. Alternatively, if you were to prime an economy when it is fully employed, there will be no changes in its employment position; all changes will be reflected in prices and inflation.

What we've tried to do here is to take these changes in tobacco sales, which represented about 7.8% of the total sales of pharmacies. We're talking here about the sector as a whole. We're not talking here about any particular pharmacy, or a group of pharmacies or subgroup; we're talking about the sector as a whole. There are pharmacies that sell 40%; for some, 60% of their sales is tobacco; for some, as you know, a good number of them, don't sell tobacco at all. This number we're talking about is a weighted average of those selling tobacco between being independent and being a chain.

What we found is that in the short term they're unable to adjust their rent and they're unable to adjust their heating and lighting. They're not going to be able to adjust all their costs. Some of these costs are fixed. Ultimately, we found that the brunt of the adjustment will most likely be in labour costs and jobs. We've estimated that in the short term there will be about 388 jobs that would be lost at pharmacies and—I'd better be careful here—person-years of employment, because jobs depend on the mix between full-time and part-time jobs.

If you look at the long term, and looking at the thin, bottom-line margin that pharmacists operate with, 4.3%, it is unlikely that if they were to suffer an 8.5% decrease in tobacco plus companion sales, and we've chosen to look at the conservative estimate of only 25%, it is inconceivable that to maintain their profitability they would not cut, when it is possible for them to cut, their costs by 8.5%. When you do this at pharmacies, you're going to lose 1,363 person-years of employment, which is translated to about 2,746 jobs: 683 full-time, and about 2,063 part-time jobs.

The upshot of this is that this would not stop at the pharmacies' gates. Because of this impact system we have that traces all the interactions among sectors, this original change would be magnified in the economy to a much larger one.

Surely one would come back and say this loss in employment, loss in income, ultimately loss of taxes, would be made up by competing or other activities coming on stream. In the short term, we feel this is perhaps most unlikely, particularly for three reasons. We did not, by the way, say that once you didn't sell tobacco at pharmacies, it would not be sold elsewhere; no, we assume it would, but where would it be sold elsewhere?



We really thought it would go into basically three activities: one, to the underground economy, and there you don't have any measure of it to speak of or way to count; to the overworked economy through the mom-and-pop stores, which is not going to mean much change in employment; or to the other sectors, which we felt really represent such a small proportion of the total sales, because pharmacies collectively are about 12% of the total. In this respect, you don't expect there would be any compensating activities coming through.

**Mr Rutsey:** Just to make that a little clearer, of the pharmacies that sell tobacco, approximately 12% of independents' and 6% of chains' sales are tobacco sales. On an average basis, that works out to, I believe, 7.8%. When you distribute that across the other retail sectors, such as the grocery stores, gas bars and industries of that nature, if you distribute those sales in the pattern in which they currently occur within those other subsets of the retail market, their increase in sales in each of those elements is less than 1%, something of the magnitude of 0.4% or 0.8%.

That level of increase of business does not usually translate into a level of increase of employment in those sectors. So although this number is a relatively large number in terms of the pharmacy sector, ie, at the independent level, over 12%, in a sector that's operating on a net operating profit level of 4.4% of total sales, that certainly will have a deleterious effect on employment within that sector. However, when you spread those sales out across the rest of the economy, when each of the other sectors picks up less than 1%, there's little likelihood that jobs will be created in those other sectors.

The Wal-Mart theory of retailing might be a good analogy. I'm sure that everyone is spending a lot of time thinking about what the implications are. We're not here to talk about that, but it's good shorthand for looking at the way these sales will be transferred through other portions of the economy.

**Dr Kubursi:** Basically, there are two things I want to conclude with. One is that the prohibition of tobacco sales should not really be seen, particularly in the long run, to be a marginal adjustment; it represents a complete shutdown of an activity.

As an economist, I would really say that in most likelihood there would be a commensurate change in the expenditures and the operating performance of pharmacies. Here what we're really talking about is not only in terms of tobacco. Tobacco could be resold other places. It's just the fact that you don't have these particular revenues any more. You're just going to cut your cost by this much to maintain your profits. If this is the general observation about how business is run, this is the likely outcome we foresee, and in this respect we predict a very large reduction in jobs as the system churns around the implications of this.

**Mr Rutsey:** Finally, what we were also asked to do was take a look at what the impact has been of the social contract and the expenditure control plan of the province. We've done that as well because from our client's perspective three things have happened, not one thing in isolation. Our study also has our findings with respect to

the impacts of those two other items. It's our position or conclusion that these things really can't be looked at in isolation, that it's not just additive, that it could be multiplicative.

We'd be happy to lead people through our analysis around that issue, but I think we're here to talk about Bill 119 so we haven't really said too much about that. But we have done work around that that we'd be happy to share with you or discuss with you, and it is in the study.

1100

**Mr Rosen:** I want to provide sufficient time for questions because I know that's important, but before we reach the question period, there are just a few statements I would like to make on behalf of the committee.

Prohibiting the sale of tobacco in pharmacies would not result in reducing tobacco consumption by the public, because as has been indicated and as you know, other outlets would continue to sell it while new outlets would begin carrying it because it'll be an opportunity for them.

There are presently 28,000 retail establishments in Ontario where tobacco is currently sold, and that's not counting the underground market that we have no tab on. In fact, many new retailers that have never previously sold tobacco would aggressively begin to sell it. I think you can see that in the advent of tobacco inside service and gas stations. It's within the last three or four years that almost every gas station now features tobacco at an extremely competitive price, an extremely competitive legal price, shall we say.

We find this act as it's written is discriminatory against pharmacy. Prohibiting tobacco sales in pharmacies is discriminatory. It would remove the product from a responsible retailer, the pharmacist, who is experienced in dealing with dangerous and controlled products and is the one who is least likely to sell the product to those under age.

Pharmacy is an already beleaguered profession. Removing tobacco, along with the other effects that have been put forward by the social contract and the reduction in fees paid to us for our services in a professional capacity, will have a punitive impact on pharmacy's ability to serve the public. While enduring increases in fixed and operating costs as well as much higher inventory costs, pharmacy's ability to increase professional fees for service has been held in check by government controls.

In addition, there have been cutbacks in the Ontario drug benefit plan, in fees paid to pharmacies, and changes in classification of drugs that are no longer of benefit to the public. This in itself has reduced pharmacy revenues substantially.

A large number of products that were once exclusively sold in drugstores are, because of change in their status—they've been switched from what we call drug identification numbers to GP, or general product numbers; I don't want to go into it. Certain things that were formerly sold only in pharmacies as a controlled outlet are now sold everywhere.

Pharmacists have sought to counterbalance the pressure on their dispensaries by gaining on the retail side of their activities. We've tried to overcome what we're losing in income and profitability in our dispensaries by increasing

our activity in our front-shop merchandising. If tobacco is eliminated from our stores, the squeeze on pharmacy will intensify because our competitors can and will increase their offerings of health care and related products. We are already witnessing products that used to be the exclusive preserve of drugstores carried in other retail establishments.

I should add that many independent pharmacists have selected locations which were not appropriate for the major chains, but were vital for patient service and for the public interest in smaller communities and in secondary locations throughout Ontario. They are severely threatened by this legislation as well.

While we recognize that tobacco use is a very important health issue, we believe that the thrust to curb its use must be driven by education, not by prohibiting its sale in pharmacies. If the goal of a smoke-free society is to be achieved: education, education, education. If it's going to be cool for kids to smoke, kids are going to smoke. We've got to change the outlook towards tobacco in young people.

We therefore offer two recommendations for changes in Bill 119. We believe that the decision to sell tobacco should remain at the discretion of the pharmacist-owner, and that pharmacists should spearhead a drive by legitimate tobacco vendors to help finance an information campaign through the media to educate Ontarians to stop smoking.

I want to thank this committee for the opportunity it has given us to make our presentation. We'll now try to answer any questions you may have of my committee members or of our consultants.

**The Vice-Chair:** There's a short time for questions: one question each per member if we could, please.

**Mr McGuinty:** Given the importance of this presentation and the fact that we have the first introduction of what I think are some objective data on this, perhaps we could extend the time frame. I would certainly be prepared to do that.

Gentlemen, first of all, thank you for the study. I'm not an economist. It surprises me that the government did not conduct its own study to look at what will be a downside to the pharmacy ban. But I want to question this a little bit.

We're talking about 2,700 total jobs. When they talk about probability, statistics or polls, they talk about a plus and minus figure. Let's say we bring in some other economists. What kind of variation are we talking about here? And is it possible to reduce sales 7.8% and not have an adverse economic impact? Can we do it in such a way so we don't lose any jobs?

**Mr Rutsey:** Let me give you a short answer first, because I'm not an economist either. The reason we chose Dr Kubursi, as we said, is because he has written the economic impact models for a number of ministries within Ontario. He's intimately familiar with the Ontario economy. We wanted to use modelling techniques the government was familiar with.

The second question you asked was, would different studies produce different results? Yes, just like in court,

every time you get an expert witness, you've got an expert witness who can refute the expert witness. What we wanted to do here was that we wanted to put the information on the table in as close a fashion as the government of Ontario is used to in analysing and looking at these matters.

I'm going to let Dr Kubursi give you a much more technical answer, but that was the approach we tried to use. We weren't trying to create rocket science. We tried to do this in as neutral a fashion as possible, using the economic models for the province that are most often utilized in studies of this nature.

There's a longer answer that the economist will now give.

**Mr Arnott:** We're constrained for time, so I just want to ask you a quick question. I think it's great that you've done an economic impact study and I think the government should give consideration to it. Was there any consideration on your part of surveying the vast numbers of pharmacies that have voluntarily gone out of the business of selling tobacco over the last numbers of years, whether based on their own ethics professionally, or perhaps the recommendation of the college? To me that would be hard, empirical evidence too, the direct impact they've had as a result of voluntarily withdrawing from the sale of tobacco.

**Dr Kubursi:** Maybe I'll answer Mr McGuinty first quickly, and then I'll let Mr Leonard—I did not collect the input data and maybe he can answer this.

First, as an economist, let me say this up front: I share your concern about economists portraying themselves as if they were dentists and coming with the drill to the cavity. We're much more like bulldozers and hopefully going in the right direction. The error margins are wide, and one has to really say that up front.

But let me tell you this too, that we really have two options here. We can sit back in our chairs and say there will be 10,000 jobs lost, or 5,000 or 5 jobs lost, or we can really go and use the actual data we really have.

What we have here is an accounting system that is developed and disseminated by Statistics Canada and a model that is well recognized as the technique one can use. It is as good as the data you put into it and the assumptions upon which it's predicated. I would vouch for the data, because we tried as much as possible to cross-check the data we got and looked at exactly what would be the average number of dollars that are associated with tobacco sales and how these are sustaining these sales.

#### 1110

The assumption which is extremely important here is that in the short term we don't sell tobacco; it's now sold by somebody else. Will all these jobs expected to be lost at pharmacies and outside the economy be made up by the alternative sectors that are picking it up? It is our considered judgement that they would not. It may be going into the underground economy, it may be going into the overworked economy. Again, it's spread over so much that it does not represent any major substantive change to warrant any increase of a commensurate amount in jobs as would be lost in pharmacies.



The other one, in the long run, would also again use an average, basic ballpark figure and one that is also, in our view, defensible in the sense that, if you cut a particular amount of revenue, then if you want to protect your profits that you consider to be what would keep you in this business and not to go elsewhere, you have to cut a commensurate amount of cost. Once you cut these costs, these have to percolate through the economy.

Now, given sufficient time, and other activities come on stream and one can bring a convincing argument that they would be exactly of the type and magnitude of those lost pharmacies, then perhaps some of these numbers would have to really be watered down. But in terms of the way we've really looked at it and considering the alternatives, it's our considered judgement that this is an average number that we will hang our hats on.

**Mr Rutsey:** Now Eric will try to answer Mr Arnott's question.

**Mr Leonard:** What we're looking at here, to answer a couple of parts of your question, is not the ethics of the issue; we're looking at the economics of the issue. In order to look at today's picture of the market, 1,400 pharmacists sell tobacco. We have determined the volume of tobacco sales that flow through those stores. We have done a survey of those pharmacists to determine what portion of their sales are tobacco and to determine what portion of companion products are sold along with that tobacco. Whether other pharmacists do not sell tobacco is not an issue and doesn't make a difference to the actual numbers in our report. That was their own choice. We've looked at those who sell tobacco today and the implications of this bill on them.

**Mr Arnott:** To me, the best empirical evidence you could find would be an assessment of what the effect has been for the pharmacists who have already voluntarily gotten out of the sale of tobacco.

**Mr Rutsey:** That may or may not be correct, because what we wouldn't have is the empirical evidence from every store in Ontario with respect to what volume of their sales constitutes tobacco. Someone has a very low sales volume of tobacco that may not impact that store at all. A store may have had a larger impact and it may have made some other changes within its activities. Certainly, there would have been some element of a reduction of payroll expenses.

Rather than try to do it on a one-off basis, which may in fact skew the modelling, we did it on a province-wide basis, on a more statistically valid basis. We used the entire market and what the impact would be rather than trying to pick a few and then off that model for the rest of the province, because that is not a valid way of conducting a survey or a study of this nature.

**Mr Rosen:** What I wanted to suggest to you is that of the 800 pharmacies we noted that do not sell tobacco, a majority of those pharmacies have never sold tobacco. It's the way your practice evolves. If you're a generalist, as we are, as Bernie is and as are many of those we represent, you provide health care service in the dispensary and provide convenience merchandise in the rest of your pharmacy or the rest of your store.

As it has evolved in our practices, we've always sold a mix of merchandise, tobacco included. In many other pharmacies, from the moment they've opened—they may be in medical centres or professional locations—they've never sold tobacco, so the impact of the removal will have zero effect because they were never in that aspect of the business.

For many others and a minority who have stopped selling tobacco—and more power to them; I don't oppose voluntary cessation at all; I encourage voluntary cessation—tobacco may not have been a significant aspect of their total mix, as Mr Rutsey has said. I don't know; we have no study on those who have given it up.

**The Vice-Chair:** We've actually run out of time, but two more short questions, please.

**Mr Jim Wilson:** Gentlemen, thank you for the study; 2,746 jobs is a lot of jobs. It's a study done by Coopers and Lybrand, the same people the government hung its hat on with respect to introducing casinos in this province, and it's the same type of analysis that the government hangs its hat on when the Premier talks about job creation, in terms of when the government—all governments—say they created so many jobs. They take the same type of analysis to the economy. I think you bring real credibility to the debate, because yesterday, you may know, a number of the government members were saying, "You've no proof there'll be job losses." I say that if you're even in a little bit wrong on your estimate, 2,746 jobs is a lot of jobs. You bring us a study done by a reputable firm that the government relies on from time to time. The government has no study of its own and it doesn't in any way, other than hearsay and anecdotal, produce evidence that consumption will go down if pharmacies are no longer allowed to sell tobacco products.

I'll just make that comment and then ask you a question. We hear from time to time—and I was happy to see, Mr Rosen, that you addressed the issue—of the monopoly that pharmacies have with respect to dispensing pharmaceutical products and prescription drugs. You mention that at the back of the store essentially your margins are lower and lower all the time, that with the expenditure control plan, the social contract, the changes to the ODB, you're getting hit pretty hard at the back of the store. Now it seems that the government wants to hit you hard at the front of the store, on the retail side.

With respect to the monopoly, can you just address that and why it's necessary for you to keep your sales at least constant at the front of the store or you won't be in business?

**The Vice-Chair:** Please make your response very short, because we're really over time.

**Mr Perruzza:** Point of order, Mr Chairman: When you say you're going to allow one question, if that includes a 10-minute preamble which is not relevant at all to what we're discussing—

**The Vice-Chair:** I'm sorry; you're wasting time, and many members are prone to that, in my view. Can we have a short response, please, because I do have Ms Haslam who has a question.

**Mr Bernie Ceifets:** I think that a pharmacy is an



unusual combination of business and professionalism. A pharmacist wears two hats. He serves the public from his dispensary and unfortunately, or fortunately, in a lot of cases this dispensary is subsidized by his retail part. We are dependent on traffic. We are dependent on sales of non-professional products, which in a way more and more subsidize the dispensing of prescriptions. It's very important to remember that the loss of tobacco is a very serious loss to the cash flow to our business, but it's those companion sales. Right now, that hasn't impacted on us. We've lost sales, like every other retailer or pharmacy, but more so we've lost them not to competitive retailers, not to people who will buy the companion product that we sell.

It's my gut feeling that 80% to 90% of my lost tobacco sales have gone to the underground. These people go and buy their tobacco from the underground: from the car, from the pool room, wherever they buy it. There's no question of age brought up. We've lost the tobacco sale, but we still have that customer who comes back and buys the shaving cream, the confectionery products, and he's still our customer. If we lose tobacco sales completely and they're allowed to be sold by a direct competitor, a convenience store, we lose the traffic from the tobacco sale, we lose the companion sale and we lose the habit of that shopper coming to the pharmacy.

I've been a pharmacist for 40 years, like Larry; I've had a pharmacy for 32 years. It's that habit, that everyday customer who subsidizes the total business. It's the front-shop customer who more and more is subsidizing the professional aspects. That's in essence what our problem is.

1120

**Mrs Karen Haslam (Perth):** I am going to do similar to what other people do. I was pleased to see a survey come forward because, to tell you the truth, when I saw the original letter that came out of my township that said 10,000 jobs, 300 pharmacies will close—now I find that you've come forward and you've scared the bejebbers out of some of my councils. I don't appreciate it.

There was a presentation recently that says they told the municipalities that 300 pharmacies will close, 10,000 jobs will be lost. There is no rational basis for this preposterous assumption. So I looked forward to this type of thing, and then I find out that your survey was 13 independent pharmacies. I really start to question. And I haven't hung my hat on Coopers and Lybrand and what it said about casinos, so I have no bone to pick here, whether I think this company is professional or not. How much did you pay for this study? I think the best study would've been to look at those stores that used to sell tobacco and whether they're still in business rather than looking at what your presumptions are.

I got dragged into this but I'm looking at this as a health issue. Do you agree that smoking has significant negative health consequences? Do you as pharmacists believe that ultimately Ontarians should move towards a tobacco-free society or as close to one as we can get?

Your arguments lead to the presumption that the financial benefit of tobacco should supersede the health benefit, and that to me goes against the relationship that you argued when you came forward saying that you want

to be judged as health professionals. When you came to another committee, you said, "We want to be in the Regulated Health Professions Act."

The bottom line is, are you a health professional or are you a retailer?

**Mr Rosen:** Your first question was the price, I think. That's a private matter between our group and the firm that was retained.

**Mrs Haslam:** Did you five pay for it? How many members do you have in your organization, in this committee? How many members?

**Mr Rosen:** We had responses from—

**Mrs Haslam:** No, how many members are in your committee?

**The Vice-Chair:** Ms Haslam, will you allow the response? Please answer.

**Mr Rosen:** We've had responses from approximately 400 pharmacies that sell tobacco in this province.

**The Vice-Chair:** And they helped pay for this study?

**Mr Rosen:** They did pay for it—not helped, they paid for it. What was your next question?

**Mrs Haslam:** Do you agree that smoking has significant negative health consequences?

**Mr Rosen:** Yes, we do.

**Mrs Haslam:** Are you in agreement that we have to move towards an Ontario where this poison, this product, this addiction should be taken seriously and look towards a negative smoking tobacco-free society?

**Mr Rosen:** We support the position that if the product is to be limited in distribution, it should be totally limited in distribution. It should be sold in tobacco control outlets and not in any competing retailers.

**Mr Ceifets:** If the government took it seriously, I think it would bring out a law that would outlaw tobacco completely and not pick one facet.

**Mrs Haslam:** Do you think the timing is right now or is this a first step towards that?

**Mr Rosen:** This is not a step.

**Mr Rutsey:** Can I make one closing statement? Our firm's name came up, and from our perspective, we're not pro-government, we're not anti-government; that's not related to the issue. What we're asked to do, what we do on behalf of the government on many occasions, what we do on behalf of the private sector on many occasions is: Given this, what might happen? That's what we attempted to do here. We have no axe to grind.

**The Vice-Chair:** Thank you very much for that information. We thank you very much for your presentation.

RETAIL COUNCIL OF CANADA

**Mr Alasdair McKichan:** My name is Alasdair McKichan. I'm president of the Retail Council of Canada, and with me is Peter Woolford, vice-president of the council. In the interests of time, instead of reading the submission, I'll briefly summarize it.

**The Vice-Chair:** I will be indebted to you.

**Mr McKichan:** The retail council, just to put it in context, is a trade association whose members among

them perform something like 60% of Canada's total retail store volume. Associated with us are some 100 either regional or commodity-specific associations, and the Canadian Council of Grocery Distributors, which is our close cousin, also supports this position.

I'll touch first, if I may, on the issue of children and adolescents in general. As an organization, we some years ago made a strong commitment to doing what we could to discourage young people from smoking. We made a commitment in 1988, when we were appearing before a committee of the federal Parliament, that we would embark on a program which would provide information to retailers, and through them to their customers, to make it quite clear that selling tobacco to minors was against the law. We distributed, to every tobacco outlet we could ascertain, material which conveyed that message.

We renewed that initiative just two years ago and we decided that it would be useful to enlist the support of the council of chiefs of police and through it the officers who are concerned with law enforcement and prevention. We jointly made a reissue of that kit, again to all the non-tobacco outlets in Canada. Some 1,100 police officers were involved in the information going to retailers.

We made a presentation in August 1982 calling on the federal Minister of National Health and Welfare to introduce federal legislation which would establish a uniform age for sale of tobacco and we suggested that age be 18 because that was the par level prevailing among the provinces. We're not too concerned whether the age is 18 or 19, but we are concerned with the issue of uniformity. We think it's still worth working towards achieving a uniform age both federally and provincially and we hope that Ontario might play its part in achieving that.

We do, as I've mentioned, strongly support the placement of signs in stores reminding retailers that the sale of tobacco to minors is illegal. The material which you will see in the kits we distributed is not dissimilar from the proposals of your government, and we would suggest that we might together approach that issue and see if we can work out a uniform approach to that information.

I think it would be useful to take advantage of the voluntary cooperation which has been demonstrated in the trade and the fact that we can, through our various retail organizations—and we enlisted the help of other retail associations which are involved—achieve very good distribution to the appropriate places.

I'll say a word on the issue of minimum package sizes. We don't have any very strong, predetermined views on this subject, except that there is certainly some demand among elderly people and people of limited means for smaller packages. We don't think the existence of small packs is really going to influence significantly the sale of tobacco to minors. The biggest opportunity for minor purchasing is now in the underground economy. Indeed, this and other measures may really have a perverse effect quite contrary to the intention of the government in relation to restricting the sale to minors.

That leads me to the next point, made halfway down page 5. The major weakness of the legislation in terms of its impact on young people is precisely that it is becoming more irrelevant with every passing day. We know

there is a huge and rapidly growing black market for tobacco in Ontario which is going to be completely unaffected by this legislation. Indeed, the greater restrictions may well have the effect of further facilitating the expansion of that contraband market. You have heard, or will hear, from those who have studied this professionally the exact dimensions of that huge market and the consequent loss of revenues to the government.

In addition to that bad effect, there is also the problem of thefts from retail stores and the assaults on staff. This is now a really serious issue for anybody involved in the retail business selling this product. Of course, the products of that illegal activity also find their way on to the black market.

### 1130

Let me touch on the issue of environmental tobacco smoke. We've no problems with the issue of prohibiting smoking in stores of any size. That, generally speaking, is a rule maintained by the proprietor of the store, in any event. We do raise the issue of the single-owner-operated store, where the individual may smoke and may not be able to leave the store unattended. It may be you want a de minimis exception for that kind of operation.

On the issue of information about health consequences, we do make the point that the point of sale in any retail store is a very space-limited and attention-limited environment. We doubt whether you can convey two messages at the same time. We doubt also whether it's realistic to load up the point of sale with more than one sign devoted to the tobacco issue because realistically, I think if you attempt to do that, it will simply not be observed in the retail trade and that law may not in fact prove to be enforceable. We would suggest that there be a single message relating to the sale of tobacco to those under 19 years. We suggest other means be used to direct the educational message.

In terms of the subject of your recent discussion, the sale of tobacco in health facilities and pharmacies, we're opposed quite strongly to the proposed ban on the sale of tobacco in health facilities and particularly in pharmacies. Tobacco is a legal product, after all, legal to sell and legal to use. We suggest it's completely unfair to prevent only one type of retail establishment from selling it. This is especially the case because it's highly unlikely that the ban will have any meaningful influence on the level of sales. We believe it will serve only to damage the economic interests of one group of specialty stores within the retail trade. It may make you feel better by passing that law. We think it will actually have no effect or even have a perverse effect on the actual behaviour of the young customers you're attempting to influence. We think it will in fact drive a substantial portion of these sales into the underground economy.

Similarly, we're opposed to the provision which prohibits the sale of tobacco in a retail establishment within which a pharmacy is located, for all the reasons we've stated. It should also be pointed out that in a large corporate store the observance of the sale to minors is probably the most strictly observed of any category of retail outlet.

We've no particular difficulty with the proposal to



monitor tobacco sales, but we don't know if it's going to provide you with much useful information.

So far as enforcement is concerned, we are naturally, of course, concerned that we have a law that people will respect and observe. We don't oppose suitable fines for retailers convicted of selling tobacco to minors. We would hope that the fines are not set so high that they drive a firm out of business, recognizing that retailing is a highly decentralized activity. You're dealing with hundreds of thousands of human beings, and all of them are prone to mistakes, not with any actual intent. But we know from experience with laws in relation to advertising, with the display of tickets on products and so on, even with the best intentions in the world, with the hundreds of thousands of people, with the millions of transactions, even if you get only 0.0001% inaccuracy, that still shows up as thousands of infractions in the huge universe we're dealing with. We ask that you bear that in mind in relation to establishing penalties.

We have no objection to the use of orders restraining merchants from selling tobacco when they have been convicted repeatedly of the sale of tobacco to minors, but we would hope that this could be achieved without recourse to a licensing system. Such a system, we know from experience, is administratively burdensome and costly.

In conclusion, we find we can support many elements in the legislative package. We'd suggest that those sections where we have identified issues or problems—they're either symbolic or they'll have little, we believe, substantive effect on the problems the government is attempting to address. If these issues were removed, we would have no hesitation in supporting the whole package. We'll be happy to respond to the questions of the committee.

**Mr Drummond White (Durham Centre):** I was very interested in your presentation. I'd like to concentrate on one area, which is the issue of some retail establishments being able to sell and others not able to sell.

This committee heard submissions in terms of the regulated health professions and then, more recently, just a month ago, heard submissions in terms of an amendment to that act. In both those situations we're hearing from pharmacists who are saying: "We're health care professionals. We are apples." Now, the same group is saying: "No, we're not apples; we're oranges. We are retailers." So we, as a committee, have to determine whether they're apples or oranges when they present both.

I'm not asking you to deliberate on that. What I am asking you to do is to comment upon the report we have. We've had some very expensive reports. Yesterday this was from the Canadian Association of Chain Drug Stores. They presented a report which was extremely expensive. Of course, they didn't tell us how much, but they had a video—a very, very smooth operation.

To quote from that: "Our research indicates...pharmacies are less likely than other retailers to hold dual inventories of both illegal and legal tobacco products," that is, legal cigarettes and contraband cigarettes. But convenience stores, bars and restaurants—other members of your council say they normally, habitually, commonly

sell contraband cigarettes. They contrast themselves. They say, "We're retailers, but we're better than the other retailers."

Further, in terms of the sale of tobacco products to minors, they say: "Pharmacies undertake extensive training of employees to ensure that no cigarettes are sold to minors." However, "convenience stores in Toronto, for example, have been raided many times for selling contraband products. Yet the economic rewards are so lucrative that they remain in the business." They continue to sell to minors, this report says, while pharmacies, drugstores, do not.

On the one hand they're saying, "We're not retailers; we're professionals," and then again, when they say they are retailers, they say, "We're retailers, but we're a cut above the rest."

I notice with the material you've circulated a very extensive campaign that you've undertaken to proscribe the sale of tobacco to minors. I notice in your brochure that you have a number of groups supporting you. I don't notice on that the Canadian chain drug association, Shoppers Drug Mart or any of the other groups who were telling us they're a cut above you.

**Mr McKichan:** Most of these companies are direct members of the Retail Council of Canada, so they would be represented in that way, whether or not they're also represented in the chain drugstore association.

**Mr White:** But do they also independently support the association? Do they also support you financially, as these other groups we've noticed?

**Mr McKichan:** Yes. Not all the members of the Ontario chain drugstore association are also members of the retail council, but many of them are.

**Mr White:** I'm wondering if you could comment on this issue that this report brings up, that pharmacists and drugstores are better retailers than the rest.

**Mr McKichan:** I would suspect that in the group you are mentioning, because they are disciplined types of companies, they probably are able to achieve a better level of enforcement than is the case with others who are less professionally directed or managed. That's probably realistic.

1140

**Mr White:** Do retailers generally sell contraband materials, as this document indicates?

**Mr McKichan:** I wouldn't say regularly. I'm sure some do. We're dealing with a universe of tens of thousands and I'd assume, human nature being what it is, not all of them are going to obey the law.

**Mr Jim Wilson:** It's always very good to hear from the Retail Council of Canada.

I gathered from Mr White's comments that only the government can produce expensive reports and that if anybody else goes about doing anything along those lines it's somehow immoral, wrong or—

**Mr White:** Point of order, Mr Chair.

**The Vice-Chair:** Proceed with the question please, Mr Wilson.

**Mr White:** I just want to point out that this is not a



study from the government, this was from a—

**Mr Jim Wilson:** That was my point.

**Mr White:** Perhaps he should have listened.

**The Vice-Chair:** Please, can we proceed with the question?

**Mr Jim Wilson:** It's an important point because it's exactly what Mr Arnott, my colleague, has said. The government doesn't produce any really meaningful reports when it brings in its anti-business legislation, and yet when some group—regardless of who they are, as long as they're from the private sector and trying to create jobs in this province and keep people employed, you guys have a bent against them and they can't get out of the starting blocks with their arguments.

I strongly feel that way and we hear the usual NDP nonsense you've been campaigning on for years. Here we have the Retail Council of Canada and you take the opportunity to ask a question about some expensive report, which is the thrust of your question, and not in any other way.

Do you think it would have been necessary for these hearings to have been conducted at all if the government hadn't put in this one anti-business section of the bill? From the opposition comments in second reading and my comments on behalf of my caucus on second reading, we don't have any major disagreements that we couldn't have sorted out prior to these hearings except for this one provision. It seems to me the hearings are boiling down to that. You mention in your summary comments that public support of this legislation would be greatly enhanced if that provision were removed and I want to give you the opportunity to comment on that again.

**Mr McKichan:** We probably still would have wanted to make some constructive comments and suggestions in relation to the rest of the bill, but in terms of the content of the bill, we think the issue which has attracted the most attention, that's to say the treatment of pharmacies, is obviously the one which is creating the most concern and it's one which we believe, if passed, would not achieve the objectives for which it was conceived: the minimization of sales to young people. To my mind, it might well have a completely perverse effect.

**Mr Peter Woolford:** Mr Chairman, could I pick up on that for a moment? I think what Alasdair has alluded to at the end is particularly important. We would have appeared regardless, because the government has hung so much of this on deterring young people from smoking, and in our sense, so much of this bill, as Alasdair said in his opening remarks, is beside the point. There is a large, rapidly growing market out there which is eager to serve young people at a price less than half what they can get in any retail store selling legitimate tobacco.

In that sense the legislation is simply wrongheaded and beside the point, and we'd have to make that point regardless of what elements were in there. We're not opposed to them, but the government needs to understand that if it thinks this is going to stop young people from smoking, it's wrong.

**Mr Jim Wilson:** That's a very good point.

**Mr McGuinty:** I want to capitalize on your expertise

in the retail sector, because I'm not a retailer, never have been. We're not experts, and I don't think any of us sitting in this committee pretend to be, in that area.

We've had one study presented to us, the presenters just before you, so we've got something on the table. Let's say there was an outright ban of cigarette sales and let's just make the next assumption that your cigarette sales constituted 7.8% of your total sales. Could that happen, that outright ban overnight, and not result in job losses?

**Mr McKichan:** It's beyond doubt there would be job losses, and substantial ones. I think there would be many categories of stores which would go out of business, particularly the convenience store category, some pharmacies, I would assume, some other variety and chain stores for which tobacco is an important commodity in itself in terms of yielding profit but, more important, it is an important traffic inducer. For many stores that's the most important characteristic of their tobacco sales. It's less their profitability and much more their establishment of a visiting practice on the part of their customers.

**Mr McGuinty:** Just a final comment. I'm sure you gentlemen can read the writing on the wall. It's my fervent hope that some day we won't be selling tobacco anywhere in this province, and any assistance you can lend in that regard would be greatly appreciated over the years.

**Mr McKichan:** We certainly recognize the responsibility of the industry to bring the appropriate messages in terms of the law to customers, and I would predict that we'll continue to do that. Realistically also we have to recognize that we have a very strong model as to what happens if you attempt to legislate against the inclinations of a significant percentage of the population in terms of the prohibition of alcohol sales. You don't eliminate the sales. You just drive them somewhere else.

**Mr O'Connor:** I appreciate the work the council's been doing, and these types of stickers and what not are quite useful. You'll note that across Canada the common denominator seems to be heading towards 19, so I guess there will be a need for some changes in this.

I just wondered about monitoring for compliance of this. Did you do any kind of survey, an update, to make sure it's complied with? It is the young people we're trying to protect here.

**Mr McKichan:** One of the reasons we sought the participation of the Ontario Association of Chiefs of Police was to do precisely that, to enrol the help of the community officers in each municipality. Our experience is that the ability to do that is very much dependent on the nature of the community. In areas that you might say are comparatively law-abiding, it's a relatively high priority. In areas where more serious crimes are prevalent, then willy-nilly it's not so high on the roster of the community police officer's responsibilities. But we felt it was a useful and positive way to bring to the attention of retailers that in fact this was the law and the police were behind it. That seems to have worked to a significant extent.

**The Vice-Chair:** Thank you for your presentation and for condensing it. We deeply appreciate that.

## ONTARIO CHAIN DRUG ASSOCIATION

**The Chair:** The final presentation this morning will be by the Ontario Chain Drug Association.

**Ms Sherry Porter:** Thanks very much. We're fighting the hunger pangs too, so it's always a bad time to be on.

Mr Chairman and honourable members, on behalf of the Ontario Chain Drug Association, I would like to begin by thanking you for the opportunity to share our association's view on Bill 119. My name is Sherry Porter. I'm the executive director of the Ontario Chain Drug Association, and with me today is Steve Mezei, who is vice-president of operations for Pharma Plus.

The Ontario Chain Drug Association is the voice of retail drugstore chains in this province. We have 10 member companies which own and operate between them approximately 700 stores in communities across Ontario. OCDA companies employ approximately 9,500 full-time workers and 14,000 part-time workers.

The OCDA supports the objectives of Bill 119. As corporate citizens of Ontario, our member companies believe that the government definitely has a role to play in encouraging progress towards a smoke-free society. In particular, we support the leadership role in educating the public about the dangers of smoking. For our part, we are proud of our record of leadership in providing information about tobacco to consumers and controlling the irresponsible sale of tobacco, particularly to minors.

As you are aware, OCDA emphatically does not support paragraph 4(2)8 of the proposed Tobacco Control Act. This section, which includes retail drugstores on a list of establishments at which the sale of this legal product would be prohibited, should be amended so that retail pharmacy businesses are able to decide for themselves whether they wish to offer this legal product for sale to customers who seek it.

1150

We oppose this ban because it will significantly damage our members' businesses. The committee is no doubt aware of that, and I am here today to suggest to the committee the public policy reasons for opposing the ban and for amending subsection 4(2) so that the ban is not imposed.

There are four basic reasons we feel the Legislature and the government of Ontario should not proceed with a ban on drugstore tobacco sales. Reasons 1, 2 and 3 are that the proposed ban would be all pain, no gain and unfair. The fourth reason is that the proposed ban is out of step with the new direction tobacco control appears to be taking in this country.

This morning you heard the results of a formal economic impact study regarding the effects of Bill 119. The study concluded that over 2,700 full- and part-time jobs would be lost if the ban were imposed. That's what we mean when we say paragraph 4(2)8 is all pain. Some 2,700 jobs is not a matter to be taken lightly at the best of times, let alone in the current economic climate. Whether the burden falls primarily on workers who are full-time or part-time, organized or unorganized, over 2,000 part-time and almost 700 full-time positions will be terminated. As is the case throughout most of the retail

sector, these workers are primarily women, young people and new Canadians. Surely this is not a group upon which the government wishes to visit further hardship. A government that just announced it will spend \$34 million to help create 1,100 jobs at Ford of Canada ought surely to be prepared to amend this bill in order to save the 2,700 jobs.

What will the province receive for all the pain? The answer is: no gain. Banning the sale of tobacco in retail drugstores will have absolutely no effect on smoking in Ontario. The Lindquist, Avey, Macdonald, Baskerville study on distribution presented yesterday demonstrated that if people can't buy cigarettes in drugstores, they'll simply buy them elsewhere. The study, presented by the Canadian Association of Chain Drug Stores, showed that retail pharmacies are one of the government's best allies in responsible distribution, consumer education and, most important, refusing sales to minors.

Sending tobacco consumers out of drugstores and into a less-regulated environment such as convenience stores—or, worse, to the contraband market—is simply counterintuitive. Moreover, as the Lindquist study pointed out, cutting off legal distribution channels encourages the use of the illegal channels. At a time when the government of Ontario is moving aggressively and at some cost to attack the black market's cost advantages, it should not enhance the black market's advantage in convenience through the drugstore sales ban.

The third argument against the bill is that it's patently unfair. The ban would prohibit one kind of store from selling this legal product and say to the store next door, "Go right ahead." If the government wants to ban the sale of tobacco, it should consider doing so. If it wants to put all tobacco sales in government stores, it should consider doing that as well. If it wants to make smoking illegal, it should do that as well.

I might mention here that one of the major members of our association doesn't feel that this ban goes far enough, told me this morning to make sure I reinforce that point to you, and will stand up in court any time and say it. The fact of the matter is, it's unfair to make any kind of retailer stop selling a legal product unless you make all of them do so.

The anti-smoking lobby has singled out drugstore sales because they argue that it's inconsistent for a pharmacy to sell tobacco. The argument of inconsistency is made every day by dozens of single-issue interest groups that approach retail drugstores demanding that they stop selling legal products the pressure group happens to disapprove of. Animal rights activists tell us it's inconsistent for us to sell animal-tested health and beauty products. Environmentalists tell us it's inconsistent to sell disposable diapers. Right-to-life groups tell us it's inconsistent to sell contraceptives. Our companies receive these representations, make their judgements and basically let the market decide. The government cannot get into the business of choosing on behalf of drugstore owners which legal products may or may not be put on our shelves, especially if it leaves other kinds of retailers alone, as this bill would do.

Behind the argument of inconsistency is the question



of the nature of the retail pharmacy. As some of those who favour the ban have stated, "Pharmacies have to decide whether they're retailers or health care providers." The truth is, they're both. The prescription sales in the back of the store and the general merchandise sales in the front of the store are both essential components of drugstores today. Although there is still a number of pharmacies that serve mainly as dispensaries, almost all chain drugstores have a much more balanced mix of front- and back-of-store sales. After all, a drugstore location in a major shopping mall cannot rely on prescription sales alone to carry the rent.

Within chain drugstores the interrelationship between the front- and back-of-store sales is very complex. Most of the time, people who come in our stores for a prescription purchase some general merchandise as well. Other times, people will move their prescriptions to a drugstore that has the best mix of health and beauty aids in order to make all their purchases at this one location.

The mix of front- and back-of-store sales is different in every single one of those 700 chain drugstores. It's a very diverse industry within the low-margin, highly competitive retail sector. This industry is simply too complex for anyone to make sweeping statements about the ability of drugstores to survive without tobacco sales. Some can, many can't. It depends on what mix of prescriptions you have and the general merchandise the store finds that works best for it, and on the historical place that tobacco has in the store. It shouldn't depend on government decisions about the right to sell legal products.

The OCDA believes that unless both parts of the retail pharmacy are functioning effectively the store cannot be profitable. A ban that may seem sensible viewed from the back of the store would be suicidal to the success of the front, and thus to the enterprise as a whole. To impair sales at the front of the store is to impair the ability of the store to operate as a whole and to fulfil its health care delivery role. If the government wants retail pharmacies to continue as the vehicle for delivering this important health care service, it mustn't damage the engine that runs the front-of-store sales.

The proposed ban would be all pain, no gain, and unfair. But there's something else OCDA wants the government to consider very closely: that the proposed ban is fundamentally out of step with the direction tobacco policy is taking in this country.

To begin with, Ontario is not the only province to have considered this approach. Both Quebec and British Columbia examined the option of a tobacco sales ban in pharmacies. Both came to the conclusion that it was wrong. Quebec abandoned the option between the issuance of a discussion paper and the introduction of legislation. British Columbia abandoned it before its discussion paper was put forward. We urge members of this committee and the government to consult with their counterparts in these jurisdictions and ask what they think of the ban. The answer will come back, we feel: all pain, no gain, and unfair to the point of being unconstitutional.

As well, these provinces backed off from a sales ban because the course of tobacco regulation and control in Canada is undergoing a massive shift. For a generation,

tobacco policy has been fundamentally based on a two-track approach. These are the combination of demand-side measures, which include consumer education and the limitation of smoking environments, and the supply-side measures, which mainly have been taxation. Both have been steadily applied to (1) make people want to smoke less, and (2) make it harder to buy cigarettes. The results have been impressive, but governments in Canada, including Ontario's, have reached the limits of the supply-side approach. The rise of the contraband market, which is the direct result of the attempt to make cigarettes harder to buy, has brought upon us a massive social problem the extent of which we have not yet fully comprehended.

With the plan to slash tobacco taxes currently being negotiated, Canadian governments are in effect abandoning the supply-side track of the tobacco control strategy. In Ontario and across the country they are courageously facing up to a very difficult public policy choice. The question is, what will the new strategy be? The government of Ontario has not arrived at an answer yet and, as we all know, the policy thrust of Bill 119 was crafted long before the old supply-side taxation approach was abandoned. The ban on pharmacy sales of tobacco was an extension of the general effort to make tobacco harder to buy. In addition to high taxation, the ban would have attacked the availability of cigarettes through restricting distribution.

Now that the taxation thrust of the supply-side effort to make tobacco harder to buy is being curtailed, is this really the time to charge ahead into a whole new field of supply-side tobacco control? The blunt fact is that the entire supply-side track of tobacco control needs to be re-examined. This re-examination hasn't occurred yet, but it's one that OCDA looks forward to participating in.

What we cannot accept and what no responsible elected or unelected official can condone is charging forward with one last effort at supply-side management at the very time when a complete re-evaluation needs to take place. The proposed ban on the sale of tobacco in pharmacies is a museum piece, in my words, and part of a failed approach to tobacco control. It's an expensive museum piece which can be purchased only at the cost of 2,700 full- and part-time jobs in Ontario.

At this moment in time, Ontario needs a new tobacco strategy which takes into account the new realities of the past two or three weeks that we're facing up to. It needs a strategy that's in line with that of other provinces. It needs a strategy that does not inflict economic damage and job loss. It needs a strategy that is fair. Ontario needs a strategy that will work and make a positive difference on this important public health issue.

Ontario's chain drugstores believe that paragraph 4(2)8 of Bill 119 is not part of that strategy. We would be pleased to work with the government and other stakeholders to begin work on developing a new tobacco strategy. In the meantime, however, we urge the government to reconsider this ill-advised proposal to ban the sale of tobacco in pharmacies, and the committee to amend the bill so that it is not carried out. Thank you. We'd be happy to answer any of your questions.



**Mr Jim Wilson:** Thank you for a well-presented and certainly well-written brief, in my opinion. You talk about the fairness issue. You talk about the inconsistency argument that's put forward, and that over the years a number of different interest groups have come forward and asked you as pharmacies to stop selling one product or a set of products or another. I noticed in yesterday's Toronto Sun, in the World Report, that the Pope has asked that pharmacies stop selling condoms, particularly Catholic pharmacists. Do you think pharmacies should stop selling condoms?

**Ms Porter:** I'll give that to operations.

**Mr Steve Mezei:** The answer is no.  
1200

**Mr Jim Wilson:** I'll probably get excommunicated for now having put the Pope in the same category as other interest groups, but being Catholic, I'm willing to take the risk.

None the less, it does raise the concern, because I've heard, both before this committee and in private meetings, about the controversy at the college of pharmacy. A gentleman yesterday, who happened to be of the Jewish faith, said to me, "What if the college of pharmacy was taken over by a bunch of Catholics, and the Pope"—

*Interjection.*

**Mr Jim Wilson:** A lot of the government's reasoning on this is that the college of pharmacy—and I've done my own survey, which I'll introduce in evidence at some point—has said that it wants this ban and it believes it has its membership behind it, or regardless of that, it's not a popularity contest, so it doesn't even care whether it has its membership behind it. The Pope has much the same view: It's not a popularity contest with respect to the sale of condoms. What if it was taken over by an interest group and it decided that you should stop selling something that I think most people would agree is helpful to the population? Would the government then move on such a thing?

**Ms Porter:** That's obviously a very good point. I tried to make that point when I said that we do get representations from special-interest groups. I hope that anyone who was listening to what I said would say, "Of course you're not going to stop selling those products." You just don't react that quickly in a retail environment and it's not the way you do business.

**Mr McGuinty:** I am, and I think legitimately, confused as to what's going on with the pharmacists in this province. We've heard that the college asked for a ban in 1990. Where do pharmacists stand now and why did they ask for it? Obviously, there's division. Was a survey ever conducted?

**Ms Porter:** You've hit it right over the head. I think you've come to the point exactly that there is a profession divided and it's divided along certain lines, a lot of it along retail pharmacists' lines. It's also an issue that really stumps me when public policy is going to be decided on an issue that has so clearly divided a profession. I have to ask the question of the committee, as well as the government, about that.

There was a study carried out by the Ontario Pharma-

cists' Association on this question and the results were that 62% of the respondents favoured the voluntary removal of tobacco, not a legislated removal.

**Mr McGuinty:** When was that study done?

**Mr Mezei:** In 1992. But the other thing you should be aware of is that the council members that made up the college that brought forth the proposal, almost all of them, were defeated in the next election by the membership. In essence, the council did not represent the wishes of the majority of the membership.

**Mrs Haslam:** That's not what I heard, but anyway. I don't want to get into the economic impact but, like I say, I keep getting drawn into it.

You mention this report, the Economic Impacts of Recent and Proposed Legislation, by Coopers and Lybrand. You mention that in your brief and you also mention that in a press release you just released yesterday. This has a date on it of January 31. Were you a part of the funding of this particular brief?

**Ms Porter:** No, we weren't. I think you'll understand that a lot of times independent pharmacists and chain pharmacies are maybe at opposite ends of the spectrum. On this issue we were together. We both agreed on going forth to fight the ban. The Committee of Independent Pharmacists had commissioned this research and agreed to share the results with us, which we received early yesterday.

**Mrs Haslam:** On page 3 of your report you mention that the store cannot be profitable unless both parts of a retail pharmacy are functioning effectively. I have information that Michael Perley, director of the Ontario Campaign for Action on Tobacco, rejected statements by tobacco-industry-owned Shoppers Drug Mart that the ban will economically cripple pharmacies. He states that a 1992 Canadian Pharmaceutical Association survey shows that, of 56 pharmacies which eliminated tobacco sales, 59% had either no income loss or an increase in overall sales; 13 had marginal losses, and seven had moderate losses, but all 20 of the latter claimed to have recouped those losses after at most two years; and also noted that recent surveys in the Guelph area and in Ottawa-Carleton have shown that anywhere from 39% to 54% of pharmacies already do not sell tobacco products.

I am asking why you are saying that you cannot be profitable if statistically it's shown that pharmacies can be profitable and maintain their business.

**Ms Porter:** I don't know about that study and I don't know the results of it, but one comment I would make is that those pharmacies that do not sell tobacco now did so of their own free will. They probably did it over time, or else they never sold tobacco. That's what I meant when I said it's unfair.

**Mrs Haslam:** You mention time lines. It was brought forward that the pharmacists' college brought forth an idea of a voluntary ban in 1990, and I wondered if your association had done anything in that regard when you talk about reducing it over time, how your business has responded to your own college's recommendations.

**Mr Mezei:** It's a difficult one to answer, because each of the members probably approached it from a different

perspective. Certainly at Pharma Plus I think the approach we've taken was an extensive communication to our consumers in terms of signage, warning signs about the dangers of smoking.

**Mrs Haslam:** No, I'm talking about the college's decision to ask you to remove tobacco. What has your business done? You mentioned short time lines, but it isn't short time lines when the ban was being asked for in 1990. Has your business done anything to look at removing this?

**Mr Mezei:** We have reduced the amount of space and the display space that we allocate to tobacco in an effort to reduce the focus of tobacco over a period of time.

**Mrs Haslam:** Can we look at health issues for a minute now? I've got a copy of Professionalism in Pharmacy or Pharmacists Selling Ontario's Leading Cause of Preventable Death: Which Will It Be? This is put out by the Ontario Campaign for Action on Tobacco. It says:

"Benefits of the sales ban: The major benefit of the termination of tobacco sales in pharmacies is the elimination of conflicting messages about the risks of tobacco products being sent to people of all ages, but especially to the young."

I'm going to ask you the health question I asked earlier: Do you consider yourself a health professional or a retailer?

**Mr Mezei:** I would say that we're both. I think the difficulty that a non-pharmacist group would have is really getting their hands around this issue. Pharmacy is both a provider of health care and a retailer. That's where a dichotomy occurs within the profession.

**Mrs Haslam:** Do you believe we should move towards an Ontario where we are a tobacco-free society?

**Mr Mezei:** Ultimately, sure.

**Mrs Haslam:** When you talk about ultimately, I have a problem with seeing health care professionals say, "Ultimately, that's what we want. Yes, we are pharmacists. Yes, we argue we are a health profession when we come before other committees and say we are a health profession," and then, bottom line, the arguments that come forward are more in tune with the profitability of a retail store. I have a concern about that. I'm wondering where the priority for the organization that your chain drugstore is in looking at the health care or the health professionalism versus the profitability of the store.

**Ms Porter:** You've raised a very good point. Our members, in order to operate their prescription and dispensary businesses, have to operate a good front shop. You heard evidence this morning that there was going to be a job loss of 2,700, and I have to ask you, what's more important to you?

**Mrs Haslam:** I questioned that report when it came. I don't accept that report, to tell you the truth.

It's my understanding that the government in Britain has prohibited tobacco sales from pharmacies since 1987. Had you looked at any of those statistics or are you aware of any results of that experience?

**Ms Porter:** My information says the European pharmacy industry is very different from the North American.

**Mrs Haslam:** This is Great Britain.

**Ms Porter:** The composition of the pharmacies and the makeup of their product mix is extremely different and really can't be compared.

**Mrs Haslam:** So you did look into that situation when you had some of your research?

**Ms Porter:** Yes.

**Mrs Haslam:** Could I get a list? I know you came to see me and I asked for a list of your membership.

**Ms Porter:** It's in your package.

**Mrs Haslam:** Thank you. I didn't get to the back.

**The Vice-Chair:** Thank you for your presentation. This concludes the morning sitting of the committee. The committee is now adjourned until 2 this afternoon.

*The committee recessed from 1213 to 1407.*

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. Welcome to this afternoon's hearings of the standing committee on social development. We are dealing with Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others. Just before we begin with our first witness, Mr McGuinty wanted to raise one issue with the committee.

**Mr McGuinty:** Mr Chair, you'll be aware that the job losses have become an issue. We had a study presented to us this morning. Ms Haslam has questioned its conclusions. I would ask that the minister or the parliamentary assistant give us the minister's assessment of the job losses, so that we could have something we could weigh in terms of the impact this bill would have.

**The Chair:** Is that a request that information be brought forward?

**Mr McGuinty:** Yes, please.

**Mr O'Connor:** In response to that, I thank the member for raising it. No doubt as we go through the committee hearings and hear from many other people, job loss will be discussed. In some of the questions this morning, they were questioning whether the 13 people they surveyed out of the 1,400 was a good comparative for that discussion. No doubt we're going to hear a lot of different figures on this, and no doubt we as committee members can look through that and pull out exactly what is closest to where we're at. I'm not right now about to commit the minister to undertaking a survey.

**Mr McGuinty:** I'm not necessarily asking for a survey, Mr Chair, and I consider, with respect, that answer unsatisfactory. It's a very important issue. If we cannot rely on what we have, then what can we rely on? I think it's important for us to learn that.

**Mr O'Connor:** I never said it wasn't an important issue.

**Mr McGuinty:** Thank you for that.

SHOPPERS DRUG MART LTD

**The Chair:** With that, we'll proceed to our first witnesses, from Shoppers Drug Mart Ltd. Welcome to the committee. If you would be good enough to introduce yourselves, then please go ahead. We have half an hour for your presentation and questions.



**Mr David Bloom:** Mr Chairman and honourable members of the committee, good afternoon and thank you for allowing us the opportunity to make this presentation. My name is David Bloom and I'm the chairman and chief executive officer of Shoppers Drug Mart. I'm also a licensed pharmacist in the province of Ontario.

Throughout the province of Ontario there are 320 Shoppers Drug Mart pharmacies. With me today, and representing her colleagues, is Mrs Marj MacKenzie, who is the pharmacist-owner of five Shoppers Drug Mart stores in the city of Barrie.

I'd like to begin by stating that we at Shoppers Drug Mart not only fully endorse but also congratulate the Ontario government's intended purpose in the proposed legislation. The intent, to prevent juveniles from smoking, to protect the environment, to impose stiffer fines on retailers who disobey the age restrictions and overall to achieve cessation of tobacco consumption throughout the province, is commendable.

We fully support those initiatives. However, we are strongly opposed to the proposed ban on the sale of tobacco products in pharmacies, particularly paragraph 4(2)8.

Tobacco is a legal product. It's legal to sell and legal to use. It is completely unfair to prevent only one type of retail establishment from selling it. This is especially the case because the legislation will have no meaningful influence on the level of legitimate sales. Instead, it will only serve to damage the economic interests of pharmacies.

I'm sure you must be questioning the contradiction of pharmacists who, after all, are regarded as the front-line providers of health care, yet we are selling a product that does not contribute to that mission; the paradox of tobacco and the dispensary, the so-called ethical argument. The response to that is purely economics. It is purely and simply a matter of financial viability, and that is the way we at Shoppers Drug Mart and all community retail pharmacy operators who sell tobacco view it as well.

The federal government raises over \$7.2 billion in taxes and here in Ontario our provincial government also raises about \$800 million on tobacco revenues. The honourable Minister of Finance, Mr Floyd Laughren, stated last week: "I resent very much the pressures to reduce tobacco taxes. Quite frankly...because it's the last tax I'd like to see reduced. It's a very last resort. It would cost the province desperately needed revenue." I stress the comment "desperately needed revenue."

In the same way that our provincial government desperately needs the revenues from tobacco and is reluctant to give them up, so it is with drugstores. For the Ontario government, it's also an issue of economics and financial viability.

During the past three years, the drugstore industry has experienced unprecedented economic pressures and ultimately reduced profitability.

Perhaps I could refer to this pie chart which clearly demonstrates the squeeze on pharmacies we have experienced just in this past year, the year 1993. Starting from

the far right of the chart, the first factor is the recession. The second factor is wage increases and training of pharmacy technicians. The third factor is benefit costs: increased UIC and workers' compensation. The fourth factor is property tax reassessments and common area maintenance charges. The fifth factor is the Ontario drug benefit prescription fee freeze, which has been in place since 1990. The sixth factor is the social contract prescription fee reduction by 61 cents on each prescription. The seventh factor is the Ontario Drug Benefit Formulary deletions.

Firstly, the professional fee that pharmacists may charge for Ontario drug benefit program prescriptions: That fee has not kept pace with escalating costs. In fact, no new fee has been negotiated since June 1990, and pursuant to the social contract negotiations, the fee was rolled back by 61 cents in September 1993. That represents a \$4-million reduction in prescription sales for Shoppers Drug alone. Now, 61 cents sounds small; \$4 million is big.

Secondly, there have been over 100 products delisted from coverage under the Ontario drug benefit program. While this has saved the government over \$100 million, which we applaud—it's great—it has, however, resulted in significant decreases in prescription sales.

Thirdly, there's been a significant increase in property taxes paid by small and medium-sized retailers due to reassessment. By the way, we're classified as those small retailers. In some cases, we at Shoppers Drug Mart have experienced increases of almost 85%. In addition, common area maintenance costs have also risen dramatically due to requirements for waste audits and other regulatory obligations that have been introduced.

Fourthly, all employee benefit costs have increased because of the GST and increases in UIC and workers' compensation benefits.

Fifthly, wage dollars are increasing approximately 2%. Salaries have also escalated because of additional training required for pharmacy technicians. At Shoppers Drug Mart, we continue to upgrade the skills of our people, including training conferences for all our pharmacists from coast to coast. Patient counselling, as we all know, is a key component of good pharmaceutical care.

Finally, like all retailers, we have also suffered deeply during this recession.

But the question you must be asking and that I hope you're asking is, how did these seven economic factors impact on the profitability of the Shoppers Drug Mart Ontario stores during 1993? What was the financial impact? Are these a bunch of words or what was the financial impact? In Ontario, profit during 1993 was down 14% compared to 1992. The Ontario profit of Shoppers Drug Mart stores was down 14%. This compares to a Shoppers Drug Mart Canada-wide modest profit increase which will be announced tomorrow after our board meeting. Canada-wide, we had a slight, modest profit. In Ontario, the profitability during 1993, due to many of these factors, dropped 14%. The fact is that we made it up in the other provinces but had a major shortfall in Ontario.



Because of the implications of all these economic pressures on our business, Shoppers Drug Mart was forced to close six stores in Ontario during 1993. We expect to close several more in 1994. This is before we take into consideration the impact of a proposed tobacco ban. I can predict with confidence that we will be forced to close at least another 20 stores in one year alone if this legislation goes through. That will mean a resultant loss of another of another 600 full-time and part-time jobs in the Shoppers Drug Mart system.

These government cutbacks comes at a time when pharmacists more than ever are on the front line, delivering pharmaceutical care and helping the province reduce the overload on hospitals. At 3 o'clock in the morning, patients can always find a 24-hour Shoppers Drug Mart store in Toronto, Mississauga, Whitby, Ottawa and Thunder Bay, with additional openings planned for 1994.

The eight Shoppers Drug Mart 24-hour pharmacies, such as our store at Dufferin and Lawrence, filled over 140,000 prescriptions during the night—through the night, from 1 o'clock till 7 in the morning—during 1993, and hundreds of thousands of purchases for over-the-counter medication. Certainly, our 50 extended-hour stores that are open till midnight and these eight stores that are open 24 hours, that never, ever close, I believe play a key role in reducing hospital visits. By the way, we are the only pharmacies that operate 24-hour stores in Ontario and the rest of Canada.

The Ontario Ministry of Health has continuously maintained during negotiation proceedings relative to pharmacists' dispensing fees that pharmacies' front shops are expected to subsidize the cost of prescriptions and the Ontario drug benefit plan. The removal of tobacco is therefore a contradiction of this expectation because it would reduce revenues and therefore undermine this policy objective of the Ministry of Health. I believe you can't have it both ways.

My colleague Mrs Marj MacKenzie would now like to tell you about the impact of your legislation in her community in Barrie.

1420

**Mrs Marj MacKenzie:** I am the pharmacist-owner of five Shoppers Drug Mart stores in Barrie. I employ 160 full-time and part-time employees. In fact, in terms of numbers, I am one of the largest employers in the city.

I also endorse the overall intention of the legislation to stop juveniles from smoking. However, if the pharmacy provision goes through, I will be forced to close down one of those stores and lay off about 30 people. I will also be compelled to reduce the number of employees in my other stores. I predict that in addition at least three people in each of my remaining four stores will be let go.

As well, one of my locations is at the Barrie shopping centre and is visible from Highway 400. That pharmacy remains open on Sundays and every night until midnight, seven days a week. It fills the emergency prescriptions from the Royal Victoria Hospital in Barrie and from the emergency medical clinic located near my shopping centre. In fact, it is the only emergency pharmacy open anywhere from Newmarket to north of Orillia. That

pharmacy will be forced to reduce its hours.

I must cite the example of an Orillia woman who needed an antibiotic for her sick child close to midnight as we were closing. There are no midnight pharmacy services available in Orillia at that time. We stayed beyond midnight until she arrived 20 minutes later and filled the two prescriptions and the Tylenol product she required as well. We received a wonderful letter thanking our Shoppers Drug Mart pharmacist for dedicated service beyond the call of duty. I would like to remind the committee that being open extended hours is costly, but professionally rewarding and part of our total service commitment to the Barrie community and vicinity.

Please be aware that if your legislation goes through as proposed, it will not achieve your objectives other than to close down one of my pharmacies, create unemployment for at least 40 people and reduce health care services in Barrie.

**Mr Bloom:** The effects and impacts suffered by Mrs MacKenzie will be repeated across the province in all of the 320 Shoppers Drug Mart pharmacies; in fact, all pharmacies that currently sell tobacco in Ontario.

When the Ontario Ministry of Health issued its discussion paper on this act in January 1993, Shoppers Drug Mart undertook significant research concerning the number of pharmacies that sell tobacco, the share of market, public opinion surveys and other consumer research. Because of the comprehensive nature of our document, I have provided a copy to each of you today, including the "Factors Impacting Pharmacy" chart I referred to earlier. We predicted that there would be job losses in the industry. We further predicted that there would be closures of some pharmacies in the province. In addition, many other services we provide, such as free delivery to the sick and elderly, midnight and 24-hour pharmacies, would have to be reviewed and some cut back.

Earlier today you heard the independents' presentation by Coopers and Lybrand. Based on their research, they predicted that 119 pharmacies that sell tobacco would close down, resulting in the loss of some 683 full-time and, I'm told, 2,700 part-time pharmacy jobs. I believe their evidence is statistically valid whether you like this revealing news or not.

There is no comparable research of any kind undertaken by the Ministry of Health to support its recommendation to remove tobacco from pharmacies. The Ministry of Health has not conducted any economic impact study, nor has it conducted research to prove that the pharmacy ban would reduce the incidence of tobacco consumption. Surely it has to be incumbent on them to do so before they enact such a significant piece of legislation.

Even the health care groups that have testified before you agreed, and I heard it yesterday, that the pharmacy ban would not reduce tobacco consumption. The pharmacy ban in the bill is based on the decision by the Ontario College of Pharmacists made almost three years ago, as we all heard, in June 1991. You should know that of the elected members who supported that resolution, all but three were subsequently defeated in the elections that took place during August 1991. They were voted out of office.

The college based its decision on its mandate, which is, "To serve and protect the public interest." Our profession has questioned whether the college has overstepped its authority. After all, how will the public interest be served and protected if pharmacies close down and professional services are cut back? The college's mandate relates to pharmacists' competency, and it has absolutely no jurisdiction regarding the sale of legal products.

You should also know that the Ontario Pharmacists' Association undertook a survey in 1993 which indicated that 63% of our profession is opposed to the forced removal of tobacco. This clearly demonstrates that our profession is certainly deeply divided over this issue.

No doubt you will hear representations from other pharmacy groups and independents who may appear with petitions and who will maintain that they represent the majority in the profession who want tobacco removed. Those pharmacists have for the most part never sold tobacco, so they really have nothing to lose. However, the fact is that 1,400 drugstores in the province sell tobacco out of a total number of 2,200 pharmacies. That represents a majority of 64%. When you take out the hospital and medical pharmacies, which have never sold tobacco, the number rises to almost three quarters of drugstores, some 75%, that need and believe that tobacco is there for their economic survival.

You heard testimony from a pharmacist who claims that she removed tobacco and suffered no economic hardship. This may be true in her particular circumstance, especially if her tobacco volume was extremely low. I don't have her numbers. My assumption would be her tobacco sales were very low.

However, when your tobacco mix represents a significant part of your sales mix, such as 10% for the independent pharmacy and 8.8% in our case, which is the actual number for 1993, then you will suffer significant loss. I guess the bottom line is that every drug store is different.

Those other presentations will represent the minority of a divided profession. They have chosen to voluntarily remove tobacco, and that is their option in a free society. But for the minority to try to impose its will on the majority is both inappropriate and I believe undemocratic.

Instead of reducing the number of tobacco vendors, the void will be filled very quickly by other retailers that I believe will enter the tobacco market. Wal-Mart's acquisition of the 120 Woolco stores in Canada will give it a strong foothold in this province. They will aggressively sell tobacco because that's their American format.

We have heard that the 200 Bi-Way stores are contemplating the introduction of tobacco sales to capture pharmacies' traditional customers. Canadian Tire with its 192 stores in Ontario will respond to Wal-Mart—it will have to respond to Wal-Mart—by probably also selling tobacco. In addition, the food supermarkets and the mass merchandisers like K mart and Zellers will continue to operate pharmacies, but they could also erect special tobacco kiosks outside their doors. The playing field will become even more unlevel, to the detriment of the community pharmacy.

In effect, the legislation will have no impact on the number of retailers who sell tobacco. The 1,400 drugstores will be very quickly replaced by other retailers, and I'm not even including the gas bars and the convenience stores. There will be no impact on the incidence of smoking. So who wins? That's the big question. Who really wins in this? The answer is nobody, except the single-interest pressure groups. Everybody else loses economically.

The Lindquist Avey presentation yesterday indicated that as many as one in four packets of cigarettes in the Ontario market is contraband. Until the government takes steps to reduce this rapidly growing alternative distribution system, young people will have easy access to tobacco at prices well below retail.

What is particularly perplexing is that the government may in fact be encouraging this market. By taking tobacco out of drugstores, the government will shift the purchases away from us and move them to the irresponsible vendor. Unfortunately, all too often these vendors not only sell contraband, but they also do not pay taxes on their illicit cigarettes.

Worst of all, they do not care about the age restrictions. In fact, minors rely on these vendors for their source of supply. Pharmacies, more than any other retailing segment, enforce the age requirement and also do not carry illegal inventories. Pharmacists, who are accustomed to dealing in controlled substances, are the most responsible retailers of tobacco.

At Shoppers Drug Mart we have a corporate policy that all new employees must be made aware of the age restrictions and must view a special training video about this issue. I have a copy with me today if anyone would like to see it. We also require new employees, as a condition of employment, to sign a statement that they will not knowingly sell tobacco to minors. If they violate that provision, they will be immediately dismissed for not following company policy.

Ontario is not the first province to consider legislation to remove tobacco from drugstores. The government in Quebec considered a similar provision but did not proceed because it realized it had constitutional implications. In British Columbia, the Ministry of Health recognized the economic implications that tobacco removal would have on pharmacies in the province, and, coupled with the constitutional issue, elected not to proceed.

On behalf of the 320 Shoppers Drug Mart pharmacist-owners like Mrs MacKenzie and their staff of over 10,000 employees in Ontario, I urge you to seriously reconsider the pharmacy provision in the legislation in view of the devastating economic effect it will have on our businesses and the subsequent impact it will have on the communities where we deliver health care.

In conclusion, I want to state that the contraband market is a scourge on our society. The anti-smoking lobby advocated that higher taxes would reduce consumption. They were wrong. Instead, it has done the exact opposite. It has encouraged the contraband, brought in the criminal element and effectively made cigarettes cheaper and more accessible to minors. The exact reverse was achieved.



The anti-smoking lobby is now advocating removal from drugstores, and they'll be wrong once again. It will have no impact on consumption whatsoever. Instead, it will close down pharmacies. It will punish pharmacists and put people out of jobs in an economy where what we need least is the loss of jobs. It will reduce the delivery of pharmacy services, and the citizens will be denied convenient and accessible health care. All this will be a disaster for the province, and in the end the main objective of this legislation, which is to prevent young people from smoking, will not have been achieved.

We therefore recommend that you pass the legislation but that you remove paragraph 4(2)8 and that you engage pharmacists to work with the government to achieve your objectives to prevent juveniles from smoking.

I thank you again for this opportunity to be here today. Both myself and Mrs MacKenzie will answer any questions you may have.

**The Chair:** Thank you very much for your presentation and also for the additional documentation that you brought for the committee. We have limited time but we'll begin questioning with Mr Wilson, if we could keep it to one question, please.

**Mr Jim Wilson:** I will try, Mr Chairman. Mr Bloom and Ms MacKenzie, thank you very much for appearing before the committee today. It appears to me, and before your presentation came to similar conclusions, that the banning of the sale of tobacco products in pharmacies doesn't seem to make any economic sense. You've quoted the opposite in terms of using the government's own arguments of why it has to make \$800 million a year on tobacco sales for economic viability, and the same holds true in the free market, in the private sector, with respect to drugstores.

We've had the government admit that it in no way can prove to us that the ban will in any way reduce consumption, particularly among young people. Given that there don't seem to be any economic reasons, no market reasons, and there don't seem to be any health reasons that anyone's been able to prove to us, in your heart of hearts, in your gut, why do you think the government's moving ahead with this anti-business measure?

**Mr Bloom:** That's a very challenging question. I've heard many reasons. One is that people have told me that the government feels there are too many pharmacies in the province, so this is a way of pruning the weaker ones, and of course it could have an impact of, hopefully, filling less Ontario drug benefit prescriptions. That's the one that seems to prevail right now.

**Mr Jim Wilson:** In second reading, the Premier happened to be doing House duty that night. It's the first time I'd ever seen him do House duty and he made a big thing of it. When I got to the part about pharmacies and said it was an anti-business thing, he yelled out: "You lost me there. Have you ever heard of Imasco?"

I kept thinking, and to this day—I don't need you to comment on it, because it's my own thought. I just wondered, if Shoppers Drug Mart had not arrested Lorne Nystrom, MP, NDP, whether we'd be in this predicament. That was suggested to me a long time ago, prior to

second reading debate, and then when the Premier kind of lost it during my remarks, it stuck with me. Without hesitation, stick that on the record, Mr Chairman.

**Mrs Haslam:** Oh boy, I refuse to sink to that level.

In the Brant county submission—they're coming in next; I like to read ahead—I found that 90% of Brant county pharmacists felt that selling tobacco contradicts their professional code of ethics and only 3.3% did not feel this way, and there was 6% undecided. We have a lot of facts and figures and I want to get a couple of technical questions in, please, before I get into the health.

In this brief, you've indicated an overview of tobacco retailing in Ontario. At the bottom you indicate the total number of pharmacies, 2,257, and the total number of pharmacies that sell tobacco, 1,427. Are you included in that 1,427?

**Mr Bloom:** Yes.

**Mrs Haslam:** The reason I ask is that we had the Committee of Independent Pharmacists come and it said it represented those pharmacies that sold tobacco. I was questioning them on this report that you also have quotes on. Have you at any time, though Shoppers Drug Mart or through the Ontario Chain Drug Association, contributed financially or with work in kind to the Committee of Independent Pharmacists?

**Mr Bloom:** Absolutely not.

**Mrs Haslam:** This is your presentation.

We get a lot of things here. This was from a local action group that says, "We know that pharmacies are responsible for a percentage of tobacco sales and we think they should not take place in stores that are supposed to be selling products promoting better health." Bottom line, that's the question. Do you agree that smoking has significant negative health consequences? Do you, as a pharmacist, believe that the ultimate goal of Ontarians is to move towards a tobacco-free society? Taking a look at those two answers, how that affects your decision to let the economics overrun a health policy here.

**Mr Bloom:** I think a pharmacist is both. A pharmacist is a professional and a pharmacist is a retailer. I can give a good example of that—

**Mrs Haslam:** But you came before another committee arguing for pharmacists to be covered under the Regulated Health Professions Act as health professionals.

**Mr Jim Wilson:** As a pharmacist, not the store.

**Mrs Haslam:** No.

**The Chair:** Order, please. Let the witness answer the question.

*Interjections.*

**The Chair:** Order, Mr Wilson. Order, please.

**Mrs Haslam:** Are you a health practitioner or a retailer?

*Interjections.*

**The Chair:** Order, please. Allow the witness to answer the question.

1440

**Mr Bloom:** I've stated to you that a pharmacist and



a pharmacy have a dual role. You're the pharmacist with the professional advice in the back of the pharmacy. Once you move into the front shop, you're a retailer, and you can wear two hats. A good example is Mr McGuinty here, who's both a lawyer and also a politician.

**Mr McGuinty:** Two strikes.

**Mr Bloom:** I must also tell you that in the Ministry of Health you seem to pinpoint the fact that we wear two hats. When we're negotiating the professional fee and we're claiming that it's not enough to survive, the response is, "But you have the front shop to subsidize you." Then of course when we're talking about the tobacco issue, the response is, "But you have the pharmacy to subsidize you." You can't have it both ways.

**Mrs Haslam:** No, I'm talking about a health issue.

**The Chair:** I'm sorry I'm going to have to cut in here. I regret it. We could probably go on for a while with more questions, but we have gone over the 30 minutes, and as Chair I've got to try to keep some order. I thank you very much for coming before the committee today and for your presentation.

**Mr Bloom:** Thank you for your attention and giving us this opportunity.

#### HEART AND STROKE FOUNDATION OF ONTARIO

**Ms Rosemary Leach:** I'm Rosemary Leach, manager of professional education at the Heart and Stroke Foundation. Dr Anthony Graham will be presenting our presentation.

**The Chair:** Order, please. Sometimes after lunch committee members are very talkative. Sorry.

**Dr Anthony Graham:** I'm delighted to be here with the committee being awake. Some have another physiologic need after lunch.

I'm a clinical cardiologist and I work at the Wellesley Hospital. I spend most of my time treating people with tobacco-related diseases. In fact, this afternoon, that's what I'm usually doing, but I decided it would be more useful to spend my time here this afternoon, because I think ultimately we all in this room can save more lives by what we're doing, relating to public policy development, than I can spend probably in the rest of my professional career dealing one on one with patients.

I'm also here because I'm a volunteer with the Heart and Stroke Foundation of Ontario, which is a volunteer-led organization of 70,000 members, citizens of this province, organized in 90 chapters across this province who raise money from millions of ordinary Ontarians to fund heart and stroke research and education carried out across this province. One of the key roles of our organization is to encourage the development of healthy public policy relating to heart-healthy living and therefore ultimately curing and preventing our number one killer.

What I'd like to do this afternoon is really four things. The brief from our foundation is before you and I'm not going to go over it in detail. I'd like to highlight and I'd like to amplify certain aspects, and I'd be very prepared to answer any questions.

First of all, I'd like to applaud the government, and I'd

like to applaud all the parties that have made tremendous progress to bring this bill to the present state. At a personal level, I've had discussions with senior members of the government who have shown great vision and courage in bringing this piece of legislation forward. I've also spoken with the leaders of the opposition, Mike Harris and Lyn McLeod, and their support and the support of their parties have been very important and continues to be important on what I view as a non-partisan issue relating to the health of the people of this province. That's really why I'm here today, because I think we all can make this legislation, which is good now, even better.

I'd like to cover three areas briefly. First of all, I'd like to tell you why the Heart and Stroke Foundation is interested in this issue at all. Secondly, I'd like to talk about this particular bill and how it relates to heart health. Thirdly, I'd like to talk a little bit about ways I think this bill can be strengthened and the importance of a comprehensive approach to tobacco control in this province.

The Heart and Stroke Foundation, as I mentioned, is really in the business of reducing death and disability relating to heart disease and stroke, which as I think you're well aware, are our commonest killers, killing approximately 40% of all people in this province. Tobacco, as we all know, is the single most important, modifiable risk factor for heart disease and stroke.

Each day I treat the victims of this scourge on our society. I can tell you that it's pretty easy when I have somebody in an intensive care bed who's just had a heart attack to convince them that it's in their best interests to stop smoking. But quite honestly, we all know it's frequently too late at that point in time for that particular individual. It's also not very cost-effective since that person is already consuming, by nature of the fact they relate to me as an expensive health care practitioner, a lot of dollars.

We're really talking here about trying to do something at the front end of the problem, and I think we should be looking at that broader issue rather than the specifics of individual points of this legislation, and keep that as our focus.

This is a true addiction. Science has proved that tobacco is an addiction in small amounts. The Heart and Stroke Foundation has been interested in tobacco control for a long time, as long as it's been known that it's been a risk factor for heart disease and stroke. We've been actively involved in a number of areas in education and advocacy, and as you know, we're a founding member of the Ontario Campaign for Action on Tobacco. We think we are not a one-focus interest group. We're a group that represents common Ontario citizens who are interested in heart health.

We know that tobacco-related diseases affecting blood vessels kill more people than automobile accidents, alcohol, murders, suicides and AIDS. This is a staggering toll on our society and the numbers are in the brief. I won't belabour them; others have.

The medical officer of health in this province has appropriately focused on tobacco as being the single,

solitary, most important public health issue we have, and this government has the guts now to bring forward legislation to address that. That is why we're here to support it.

We do have a fundamental problem, though, that we have a legal product that's an addiction. There is no other legal product that, taken just as prescribed, kills you. That's our problem, ladies and gentlemen. What we're trying to do with legislation is to try to take a legal product and restrict its access. Ultimately, the bottom line is prevention relating to tobacco, and by prevention, we mean stopping people smoking.

The figures are before you in relation to the impact of young people starting smoking, that if you can prevent them from smoking prior to age 20, in all likelihood they will never smoke. That's the battlefield and that's where we really must win, and we're not right now. That's what this legislation is largely about. One has to understand that's where we really are trying to work.

The Heart and Stroke Foundation is delighted to support this bill that mandates the increase in the legal age of smoking to 19 and the signage requirements. The issues relating to the reduction in access to outlets is fundamental because we believe that anything that will reduce access, particularly of young people, to tobacco will ultimately save lives and save health care dollars.

How can we improve this legislation? Some of these aspects you may well have already heard in other presentations. The issue relating to retailer licensing: We support the concept of statutory licensing as outlined, but we feel very strongly that it must be appropriately monitored and enforced and reviewed for its efficiency.

1450

We think the medical officer of health should be charged as being responsible for bringing forward an annual report in terms of how effectively this form of restriction is working, and if it is not, then indeed a formal licensing system will have to be put in place. The medical officer of health has defined this priority and we think that he or she in that office should be given that responsibility, much like the Auditor General does.

Another area for improvement, we feel, or clarification at least, is in the issues relating to packaging. We feel that the section of the bill on packaging must make clear that it will allow, through regulation, the enforcing of plain packaging, the banning of the kiddie packs or the sale of packages of less than 20 cigarettes, and the mandatory inclusion of health warnings. These are fundamental to the act and the regulations must be written to allow that.

The area of environmental tobacco smoke is one that we have grave concerns over. Current legislation brought in in 1990 under the Smoking in the Workplace Act has been largely ineffective in correcting the problem of smoke in the workplace. We know that 4,000 people in Canada die each year as a result of environmental smoke. We know that 50% of Canadians continue to be exposed to smoke in the workplace. We know that the vast majority of non-smokers and smokers wish prohibition of smoking in the workplace.

The current legislation does not comment on this at all and we would strongly recommend that there be a ban on smoking in internal environments at work, and if allowed, that it be only in appropriately vented areas. This, we feel, is an important strengthening of this legislation that is supported by the majority of the public.

We feel this whole legislation must be viewed not as pieces, but as part of a comprehensive strategy relating to tobacco control. As I mentioned, we have a problem: We have a legal substance that's addictive and killing. How do we control that in society? We must have a comprehensive strategy to achieve that. Whereas one can go at each individual component and say you like it or you don't, taken as a package, if the aim is laudable, the goal and the strategy then evolve. We feel very strongly that tobacco control is an area where partnerships between government at all levels, non-government organizations such as the Heart and Stroke Foundation and the general public can work together to achieve the ultimate goal.

We are very concerned about the current issues and threats about rollbacks relating to taxes. This concern at the federal level adds greater urgency to this particular bill and puts greater responsibility on its quick passage and on the importance, if the rollbacks come forward and we are very hopeful they would not, that this bill would then have to be further strengthened relating to mandatory licensing of retailers and the institution immediately of plain paper packaging. We think that would be required if the tax issue was changed in a negative fashion.

We strongly support Ontario's continued resistance relating to federal initiatives in this area. The Globe and Mail in the last 24 hours has shown what the health lobby is trying to do to support government and inform government and the general public relating to this particular issue. We will continue to do so, and we strongly encourage the Ontario government to stay the course on this matter.

In conclusion, we have a tremendous opportunity, each of us, those in government, those in organizations such as I represent, those of us in the profession and those of us in the general public, to move forward on our key public health scourge of this generation. There's wide support in the general public relating to tobacco legislation, in the health care community and also among government. We feel this is a non-partisan issue and should be moved forward with quickly. We applaud the important work of this group. I would be pleased to answer any questions.

**Mr Paul Wessinger (Simcoe Centre):** My question is perhaps more on a longer-term basis. Do you see this legislation as part of an evolutionary legislative process with respect to gradually raising the limitation of access and restrictions on smoking?

**Dr Graham:** I suggested that this must be part of an overall, long-term, evolving strategy to achieve the goal, and the goal is the eradication of smoking. That's got to be made very clear. It's going to take time. There have been significant reductions in the use of tobacco products by many within society. We're not winning in the young population. The figures would strongly suggest that.

To say what we will need over time, I don't think anybody really has a crystal ball over that. We have to



say, what's the best legislation at this particular point in time to move towards the goal? We then have to continue to monitor it, and based on how we proceed, to determine next steps.

The goal is that this should be a tobacco-free society. Let's make no bones about that.

**Mr Wessenger:** The suggestion has been made by some presenters here that the elimination of sales in pharmacies will not have any positive impact on access to tobacco or on sales of tobacco products. How do you feel about that proposition?

**Dr Graham:** I think there are a number of issues that are going on. Obviously, the smuggling issue has got to be resolved. I heard the previous speaker talk about that and I'm sure others have. This particular bill does not address the smuggling issue. Our brief did not address the smuggling issue.

There are other ways of approaching smuggling. I certainly don't come from a background to give you a view on that. I think that the issue relating to pharmacies is that pharmacists are health care providers, just as I am. If my professional organization asked for legislation that allowed me to be a better provider of care and government refused to do that, I would be very concerned.

I perceive that the regulatory body of the pharmacy industry, no matter how elected, asked government to do this over four years ago, and this legislation is the first step in doing that. I shouldn't say the first step, but it is really moving towards that and I applaud that.

**Mr McGuinty:** I particularly appreciated your comments about environmental tobacco smoke, smoke in the workplace. I'm sure that all of us here have been exposed to secondhand smoke at one time or another, in a restaurant for instance. It's simply ridiculous to think that you can have one section where there are smokers and another section when there's no partition in between. It's kind of like having a swimming pool with a urinating end and a non-urinating end. Soon we're all swimming in it.

One of the things that bothers me is that we squeeze \$800 million out of our smokers in this province. It's my understanding that none of it, not a single penny of it, is dedicated to helping those people get unhooked, so to speak. Would you have any recommendations in that regard? We have \$800 million we derive as profit off the backs of people who are addicted to cigarettes in this province.

**Dr Graham:** It's an excellent question. I appreciate your bringing it forward. When we talk about a comprehensive strategy, we must help people with this addiction. I live with this every day, because I'm trying and I don't have great methods. I can use a whole lot of things that I think work with some people, but there's nothing that works uniformly.

There is no question that we need to develop better strategies to help people who are addicted to stop, and that's got to be done by a number of providers. Government can do a certain amount, but it can't do it all.

If you're driving at the fact that there should be more money for preventive health care in this province, the answer is yes. We need to know how to deliver it,

though. Clearly there must be strategies to help the people who are addicted. Those are the people I see. This legislation is largely directed at our children and our grandchildren, and that's going to be the real benefit of this legislation. If we can stop those people from starting, we won't have to be spending expensive dollars on people like me looking after people with the diseases. That is really the issue.

1500

**Mr Arnott:** Your organization is working very hard to reduce tobacco consumption or tobacco use in Ontario and you should be commended for all the work you're doing. We certainly appreciate it.

I have a question relating to the bill specifically. I tried to talk to as many constituents as possible to get their views on this issue before I came to the committee. I've spoken to Steve O'Neill from Arthur, and Steve owns the Village Variety convenience store. He sells cigarettes. He's read the bill. He expressed a concern to me that if he were in a situation where he sells tobacco to someone under 19, he's subject to very severe penalties, very strict penalties. He says that if a kid aged 17 or 18 years old buys tobacco, there should be some responsibility placed on their shoulders as well. If he does it inadvertently or by mistake or whatever, he could still be subject to a major fine, yet for the 18-year-old who bought the tobacco, there's no offense against it and there's no responsibility at all.

In other areas we assume that an 18-year-old should be responsible. If you compare it to alcohol, an 18-year-old who consumes alcohol could be subject to a charge, so in that sense there's some responsibility put on the purchaser, in other words. Mr Wilson and I have been discussing this. Would it be your recommendation that there be some addition to the bill to prohibit the consumption or the use of tobacco, or the possession, by children?

**Dr Graham:** That's the next step. It's a very good question. The issue is, how tough do you want to be? That's the bottom line. There are a number of issues. Obviously, a 16-year-old must start to take some responsibility for their own actions. There's no question about that. The problem is that the way in which tobacco is marketed is so seductive. We don't understand the whole issues of peer pressure and how they work in that maturing brain.

The issue is that these are not really, truly informed, objective consumers. They get started and then that's it. This isn't something you can start and stop. Anybody in this room who has tried to stop smoking will understand the agony of doing it. Whether you've got a disease or not, to stop ain't easy. The issue is that we have neophyte consumers who are, for a variety of reasons, toying with this addictive product and we're having to figure out what are the strategies, the best ways to prevent them from doing that.

The practicality of enforcing what you're suggesting is another whole issue, and I'm not a legal expert or a law enforcement expert. We're in effect trying to get the word out, by education, by making the packages less sexy, less attractive, by putting in place legislation that



raises the legal age, by restricting access, and maybe by other strategies that the behavioral scientists will come to us with five years from now that will tell us, "There's a better strategy to get inside the brain of a 16-year-old or a 12-year-old who's thinking about starting." This is why the evolutionary concept has got to be considered, because we don't have all the information.

The comprehensive strategy part of it is fundamental to the success. I don't think any one part of this is going to be 100% successful. This whole bill isn't going to be 100% successful. But it's a very positive step in the right direction.

**Mr Jim Wilson:** Just along the same line, as you know, one of the controversial sections is obviously dealing with pharmacies. The government's objective, and the objective of all of us, in the bill is to stop young people from starting to smoke. I'm not convinced that by banning it in one retail sector you're going to do that.

We're floating this; we'll go back to our offices and wait for the phones to ring off the wall, I suppose. It seems to us that if you made possession or consumption illegal for 19 and under, I would think, and I'm interested in your opinion, we could drop this discriminatory practice in one part of the retail sector and everybody would have to participate in enforcement. It would be the law of the land, as it is with alcohol.

**Dr Graham:** That's certainly another model. I would take exception to the previous presenter, who may not be here to comment, but I'm talking about perception. In the pharmacies, the perception is that the pharmacist is behind the desk and he's dispensing pills, and that then there's somebody out front who's peddling Coke or cigarettes or whatever. In the pharmacist's mind, there may be the two parts of the shop, so to speak, but in the consumer's mind, a pharmacy is a provider of health care services.

The issue is that if somebody who is impressionable in relation to the purchase of a product goes into a pharmacy, which supposedly must know something about health care, and is saying, "We're going to counsel you to stop once you've started," why don't we indeed make this place of health, supposedly, a place where you can't get started? It's like a hospital. The public perception issue here is the key issue. There are economic issues and what not, but there are also economic issues relating to the 13,000 people in Ontario who die every year from tobacco-related diseases. I suggest that the dollar impact of health care resources relating to those deaths far outweighs any economic burden that would be imposed on the pharmacies as a result of this.

The issue is that there's a public perception issue of pharmacies and what their key role is. I would put it to this committee that they are providers of health care much as I am. If I become inconsistent in the delivery of my key message, I am totally useless. It's just like in the 1960s when 75% or 80% of doctors smoked. It was very difficult for them to give health care messages relating to smoking. Currently, 3% of physicians smoke. We're much more powerful as a group and credible as a group in giving these messages. Pharmacies should be the same. We all should be 100%.

**The Chair:** Thank you very much, both of you, for coming before the committee this afternoon.

Bob, do you want to comment on one document that's been circulated?

**Dr Bob Gardner:** Mr Arnott asked this morning about research that had been cited on the CBC, and it was also in the Toronto Star and the Globe and Mail, from England on the health effects of smoking. The research had to do with a higher risk of miscarriage for women whose own mothers had smoked. I've distributed a wire service article from Reuters agency in the UK to members. That's the good news. The bad news is that the article itself does not cite where the material was published. It would appear to be a report of an ongoing study. This is from a study from the Institute of Child Health at Bristol University, a seven-year study, so it will probably take us a little while to actually chase down the research because it does not appear to have yet appeared in a medical or social policy journal. But we'll continue to dig it out.

**The Chair:** Also, I would inform members that the House leaders have agreed to our request to sit on either the 23rd or the 24th. They've left it up to us to determine which day. I can leave that with you and ask for a decision later, but we have that, if you could just give that some thought.

1510

#### RESPIRATORY THERAPY SOCIETY OF ONTARIO

**Ms Yvette Dumont:** My name is Yvette Dumont and I am the president of the Respiratory Therapy Society of Ontario. I am still involved in clinical practice, mostly with paediatric and neonatal patients.

**Ms Susan Marshall:** I'm Sue Marshall. I'm a respiratory therapist and I'm presently working in home care and casually in the hospital. I see a lot of young asthmatic-type patients and I see a lot of older patients who are on oxygen now in the home.

**Mr Shawn Kenny:** My name is Shawn Kenny. I'm the president-elect of the Respiratory Therapy Society of Ontario, and likewise I'm also employed in provision of home respiratory care to adult and paediatric patients.

**Ms Dumont:** The RTSO applauds the Ontario government and the opposition parties for the political will the three parties have demonstrated in supporting and bringing forward this legislation. However, while we support the basic tenets of the Tobacco Control Act, we believe the government must strengthen this legislation in order to successfully limit access to tobacco products and prevent involuntary exposure to environmental tobacco smoke, also known as ETS.

The RTSO represents the profession of respiratory therapy in the province of Ontario. Our profession is dedicated to assisting physicians in the diagnosis, treatment and promotion of wellbeing and quality of life of patients with respiratory and associated disorders. Unfortunately, many of the patients we care for on a daily basis are suffering either because they are smokers or through involuntary exposure to environmental tobacco smoke. We see on a too-regular basis the devastating impact of

tobacco use on our patients: on children with lower respiratory tract infections such as bronchitis and pneumonia whose only crime is having parents who smoke; on adults who are battling the ravages of lung disease because of their decades of smoking or simply as a result of exposure to a smoking partner or colleague; on asthmatics whose suffering is all the more pronounced because of their exposure to ETS in their daily lives.

The direct causal link between both smoking and exposure to ETS and preventable lung disease is irrefutable. As health care professionals whose fundamental objective is to promote the best possible care for patients suffering from diverse cardio-respiratory disorders, we are here today to ask for your assistance in preventing the spread of cardio-respiratory diseases. We believe this can be accomplished in several significant ways: first, by limiting the access of young people to tobacco products, and second, by preventing involuntary exposure to ETS through strengthening of the Smoking in the Workplace Act.

In 1986, the US Surgeon General and the US National Research Council confirmed that ETS causes lung cancer in non-smoking adults and poses a significant health risk to children. It is estimated that 150,000 to 300,000 children per year in the United States suffer from lower respiratory tract infections directly linked to ETS exposure. In Canada, it's estimated that for infants to 18 months of age, there are approximately 15,000 to 30,000 children who are affected. Overall, there's the potential for 100,000 children in all of Canada.

The RTSO fully recognizes the risk presented by ETS and suggests that this is one of the most critical yet weakest links in the strategy to protect the public from the effects of tobacco. In order to provide effective protection from ETS, this legislation must be strengthened:

(1) By improving Ontario workplace smoking legislation, which has proven to be largely ineffective in guaranteeing a smoke-free workplace for employees of those who wish to allow smoking in the workplace.

(2) By strengthening the restrictions on smoking in public places to ensure that exposure to ETS is eliminated wherever possible. We would in fact recommend changing the onus of the legislation. Currently, smoking is prohibited in public places that are listed in the legislation. We would recommend the prevention of smoking in all public places except those which are exempted from the legislation. We believe this small amendment will provide far greater protection.

The primary objective of this legislation, which is to reduce the use of tobacco products by young people, is jeopardized by excluding provisions to licensed tobacco retailers, as this effectively means no control on the sale of these products to minors. The RTSO fundamentally believes that a uniform licensing system for tobacco vendors with a substantial policing and enforcement mandate would assist in the battle against tobacco-related diseases and would help prevent the sale of tobacco products to minors. The mandate should include revocation powers for any vendor found to be selling tobacco to minors and significant fines for non-licensed retailers who

are found to be in breach of the licensing restriction. Through licence fees, this program would be self-financing and could potentially generate revenues to fund education and research for smoking cessation programs.

As health care professionals, we are particularly supportive of the removal of tobacco sales from pharmacies. It is crucial that cigarettes not be distributed through pharmacies or by health care professionals. To this end, we support the Ontario Campaign for Action on Tobacco and its recommendations to better define pharmacies for the purpose of this legislation to ensure that there are no loopholes for retail establishments that contain pharmacies. As a member of the Ontario Campaign for Action on Tobacco, we fully support the positions outlined in OCAT's submission to this committee and endorse all of the recommendations contained therein.

This legislation must be strengthened in order to successfully achieve the objectives of limiting access to tobacco and to ensure protection of the public from ETS. By strengthening the Smoking in the Workplace Act, the government will take a tremendous step towards limiting involuntary exposure to ETS. Through a licensing system for tobacco retailers, the access of minors to tobacco products will be further restricted and will contribute to the prevention of smoking among young people.

We would also encourage the government to fund both public education programs to discourage smoking and smoking cessation programs in accompaniment to the Tobacco Control Act. While legislation is effective in halting the use of tobacco products, we must focus on changing attitudes and perceptions about smoking and ensure that consumers have the facts about the debilitating effects of tobacco on smokers and non-smokers alike.

**Mr Jim Wilson:** It's good to see you again. Mr Arnott made the suggestion that we're grappling with the idea that for years governments have said the limit has been 18 years of age, and if you can't buy tobacco products nor is anyone to furnish those products to you, then why in the world are so many 12-year-olds smoking? Somewhere along the line something messed up. Somebody either gave them the cigarettes or they bought them. So what do you think of the idea of just making it illegal to have cigarettes in your possession or consumption of cigarettes or tobacco products under the age of 18 or 19?

It seems to me that something has got to change, and we need a dramatic break with the past. I think Mr McGuinty actually made similar comments about a break from the past during his remarks at second reading in the House. We're going to spend the next four or five weeks fiddling around again with an approach that we're told by all kinds of groups doesn't seem to be working all that well or has become less effective over the years, the approach that government has been taking to this whole issue.

**Ms Dumont:** If we could limit the access to tobacco such as it is right now with alcohol, in that there are only licensed establishments and we have the Liquor Control Board of Ontario, perhaps we could then take it further and have the ability to actually police or fine people who have obtained the tobacco, obviously illegally because



they're underage. It might be quite difficult to do that when you have tobacco that's easily accessible in the environment, in corner stores. We're looking at native groups providing their own tobacco, so then it becomes another issue. First, I think you need to limit the access to tobacco and then put in restrictions on, if you want to take the idea, users underage, and then further police it that way.

**Mr Jim Wilson:** One way or the other, though, you have to have policing.

**Interjection:** Charge the vendor.

**Mr Jim Wilson:** Right now the vendor is getting hit pretty hard, and the act speaks at great length about identification. We've had people coming up saying we need more sections in the act further clarifying what type of identification. The poor vendor can barely pay their taxes in this day and age. Why don't we just make everybody in society responsible, not just the vendor? That is, if anybody is caught with cigarettes under the age of 18 or 19, whatever we decide, like any other law, it's responsible to point out to the police that it's wrong, there's a law being violated. There would still be an onus on the vendor, obviously; they're not to sell them. Someone standing outside the Becker store near the school smoking, I would think—I mean, we've got this thing in here about bus shelters. Now, how in the world do you police bus shelters? Well, I assume if a police officer drives by and sees someone smoking in the bus shelter, in this case, that's your enforcement. I don't imagine a lot of people are going to phone in saying that people are smoking in the bus shelter. It seems to me that whatever you do policing is a problem, and in fact this may actually solve some problems.

I just want to hear what your thoughts are. We're just floating it out, and as I say, we'll be in our offices all night waiting for the calls.

**Mr Kenny:** I don't think any of us three are lawyers to tell you whether you can do that or not.

**Mr Jim Wilson:** Look at alcohol. I used to be a park warden one summer. There are several charges under the act to deal with alcohol and underage.

**Mr Kenny:** I think as a professional society we would be supportive of any measure that would keep kids from starting to smoke. I can't see as a society of respiratory health care providers that we could be anything but supportive of such a move. We couldn't even begin to suggest how to do it, but if it can be done, we would be happy with it.

1520

**The Chair:** With that, we'll move to Ms Haslam, who will tell us how it's to be done.

**Mrs Haslam:** What a reputation I'm getting.

I really appreciate people coming in and talking about health issues and young people. That's really important.

On page 2 you mention you're encouraged by the Tobacco Control Act's emphasis on reducing the number of young people who begin smoking. Somebody came in and told us there were 3,000 young people a week who begin smoking.

Your first one is banning the sale of tobacco by licensed health care professionals in pharmacies and by vending machines. It has been suggested, in statistics that one of the companies gave us, that pharmacies sell 16% of tobacco products. That's what one of the pharmacy groups gave us as information. Given that they sell 16%, they also argued that this 16% would then go into other establishments. I'm wondering if you had a comment on that or whether this would effectively help in limiting the access to tobacco products.

**Ms Dumont:** One of the issues is convenience. If you're already in a pharmacy purchasing other items, then you don't have to make another stop, and maybe one day you won't make that second stop because it's going to be somewhere else. It seems kind of contradictory where you have a pharmacy where they're selling and promoting wellness and you're filling out your prescription for your asthma medication, and then you're turning around and buying your carton of cigarettes. So I think it's very difficult to say. That 16% may go somewhere else, but also it may turn out to be that this will not be 16% elsewhere; it may be reduced to 10%.

**Mrs Haslam:** Actually, it's been reduced from 21% to 16%, so I agree with that.

I wanted to spend a couple of minutes on the education programs. Mr Beer was maybe being facetious when he said, "Karen will tell you how to do it," but I have my own idea about what to say to young people. The previous gentleman indicated it's difficult to tell young people. They don't like to be told. I know when I say to young people, "Do you know that this can kill you?" they say, "I'm young, I've got lots of time ahead of me; I'll never die; right now my thoughts are I'm not going to die." I was interested to know what kind of education programs you thought were most effective for young people.

**Ms Dumont:** In my experience, working with paediatrics, I've found that a lot of times the use of peers—we have children who have quite serious respiratory-related diseases, cystic fibrosis and some severe asthmatics, who are very intolerant of tobacco smoke. Actually, I've had a few of them in discussion, asking, "Do your friends smoke?" Some of them admit that they do and that they understand the effects to the other person, but sometimes if you have someone who's of their own age group, they can better explain what it's like when you can't get your breath, when you have to go into the hospital and use oxygen at home. Making it an issue of young people, not just that it's something for old people to deal with, may take some of the effect away from wanting to smoke.

There's the other issue, and that's peer pressure. I think young people need to have active discussions on dealing with peer pressure and what it means to be one of the group and acceptance and what's right or wrong, that they make their own decisions and they're educated decisions.

**The Chair:** Just one more.

**Mrs Haslam:** I'll change my tack then. I want to run one by you. It's interesting you talk about peers talking to peers. Young people don't like to be manipulated, they don't like to be lectured to and they don't like to be told at 16, 17 or 18 what they should be doing with their



lives. I was wondering if one of those campaigns similar to—I think somebody in the States had it, where they said: "This is a product where if you use it according to manufacturers' directions, it will kill you. It is a product that is designed to kill its customers, therefore they need more customers and they're going to a younger and younger audience. You as young people are being manipulated by a conglomerate corporation."

Do you feel that would have as much effect as the peer idea would?

**Ms Dumont:** I think it's another way to explore how you educate young people. It's interesting, identifying the fact that young people don't like to be told what to do or taken advantage of in that situation. And it's true: It's all in how you word the question or the presentation. They have to be given the sense of responsibility and information, and then their decision is based on that. I believe that might be another way of giving them the information. It's unfortunate that we have to look at such large companies and advertising and a lot of power, and a lot of these young people may not realize that it goes beyond lighting up a cigarette. There's a lot more involved in what happens when you light up that cigarette. There's a chain of events.

**Mr McGuinty:** We've heard from a number of presenters now about this idea of prohibiting smoking in all public places unless a specific exemption is provided, and that holds a certain amount of attraction. How would we define the exemptions, though? How would you qualify for an exemption? I'll just give you a couple of examples.

One of the things that I kind of dread doing on November 11 is going over to the Legion hall, because the smoke there is just so thick you could cut it with a knife. The other place that you seem to almost have to be a smoker to gain entrance to is a bingo hall. It's really thick there too. I'm just wondering, would those qualify for exemptions, and how would we go about it?

**Ms Dumont:** As health care providers, our main focus is with health care institutions. Right now, where I'm employed we do have smoking areas for patients, and sometimes, it's kind of discouraging when you have to chase down your patient in order to give them their Ventolin treatment, pull them out of the smoking room.

Specifically with health care, we're probably promoting that more than anything about limiting access to having public smoking. On the other hand, it's been very well stated in newspapers that you have all these patients sitting at the entrance to a hospital, outside in their hospital gowns with their IV poles, because that's the only place they can have a cigarette.

**Mr McGuinty:** Can you think of any exemptions?

**Ms Marshall:** The Lung Association has a large bingo they put on and they have a section—in fact I think they even have particular nights where there is no smoking or they specifically have rooms of no-smoking bingo. A lot of that money goes back into the pot to help with education on lung disease.

**Mr Kenny:** In my respiratory home care practice, I've seen a number of our clients—interesting that you would

say things like Legion halls and bingo parlours—who are having a significant part of what had been their social life prior to going on home oxygen therapy taken away from them, not only strictly from the health aspect but from the safety aspect. They can no longer take their portable oxygen system into the bingo hall for fear of burning the place down. So where are the exemptions? Personally, I think few and far between.

**The Chair:** Thank you very much for coming in this afternoon and for making your presentation.

1530

#### CANADIAN AUTOMATIC MERCHANDISING ASSOCIATION

**Mr David Orriss:** My name is David Orriss. I'm the owner and operator of London Vending Service Ltd. I'm a vending operator and have been in the business for 25 years. I'm here today to speak to you in my capacity as president of the Ontario region of the Canadian Automatic Merchandising Association.

**Mr Paul Runstedler:** I am Paul Runstedler, vice-president of sales with Red Carpet Food Services in Toronto, a national company. I am here on behalf of the CAMA as acting treasurer of our association.

**Ms Cynthia Davenport:** I am Cynthia Davenport. I'm with the Canadian Automatic Merchandising Association and I am the manager of the association.

**Mr Orriss:** The Canadian Automatic Merchandising Association, CAMA, is a trade association representing companies and individuals engaged in the vending industry as owners and operators of vending machines and as service technicians, equipment suppliers and product suppliers. As such, we are very concerned with section 7 of Bill 119, which proposes to make it illegal to sell cigarettes through vending machines.

The most recent Statistics Canada figures for the vending industry show there are 3,363 cigarette vending machines in Ontario. CAMA's members own and operate approximately 767 of them, or just under one quarter of all cigarette vending machines in the province. CAMA has 63 member companies in Ontario that fall into the category of operator. Of those companies, 21 own and operate cigarette vending machines as part or all of their business.

The immediate effect of this legislation on our members will be to put at least two, or 10% of those 21 companies, out of business entirely. Collectively, seven of the remaining 19 companies anticipate that they will be forced to lay off at least 15 people. Expressed as a percentage, 37% of the companies that manage to remain in business will be forced to lay off one or more employees. These anticipated job losses are in small towns in northern Ontario, central Ontario, southwestern Ontario and southern Ontario, communities that have already been hard hit by the recession and large-scale layoffs.

If we use the CAMA figures as a formula and assume that our membership represents one quarter of the cigarette vending machine business in Ontario, we can extrapolate from those numbers that at least eight businesses in Ontario engaged in selling cigarettes through

vending machines will be immediately forced out of business and at least 60 people will lose their jobs if Bill 119 passes, as it is currently written.

Those Ontario vending business owners and operators who aren't immediately put out of business by this legislation will have to make do with reduced product lines. Furthermore, they will have to try to capture a piece of a market that is already saturated with products from their competitors' vending businesses.

Taking a somewhat Cassandra-like look at the future, it's not difficult to imagine that many of those who survive the initial impact of this legislation will ultimately be unable to compete against already established competitors. The result is that many will likely face bankruptcy within two years.

Another unfortunate offshoot of Bill 119 will be the inability of these small businesses to sell their redundant cigarette vending equipment. Historically, owners and operators have been able to resell their used equipment to rebuilding companies for approximately \$500 to \$800 per machine. However, since this proposed law renders these machines obsolete, most, if not all, of the province's 3,363 machines are destined to end up as scrap metal or, worse, in landfill sites throughout Ontario.

This legislation will also harm our members who are equipment and product suppliers. If their customers who sell cigarettes through vending machines go out of business or suffer severe financial losses, it will have a negative trickle-down effect on the businesses of the suppliers. This trickle-down effect could ultimately result in further job losses, this time on the product and equipment suppliers' side.

The costly and painful toll this legislation will take seems too great, especially in light of the fact that the cigarette packages sold through vending machines in Canada account for less than 1% of all cigarette products sold in Canada.

The Canadian Tobacco Manufacturers' Council reports that 1991 sales of tobacco products in Canada came to \$10 billion. Statistics Canada figures for the sale of tobacco products through vending machines totalled just under \$76 million for all of Canada, about three quarters of 1% of total sales of tobacco products.

The corresponding figures for Ontario are \$3.86 billion total sales and of that, \$22.8 million came from cigarette vending machines; again, less than 1% of all tobacco products sold in Ontario.

Until consumers started rebelling against the high price of cigarettes by purchasing contraband cigarettes, statistics tended to support the notion that there was a correlation between the high price of cigarettes and a reduction in the number of people who smoke. There is a similar correlation with regard to cigarettes sold in vending machines. Cigarettes sold in vending machines are more expensive than cigarettes sold at traditional retail outlets.

A random check of some of the 21 member companies involved in cigarette vending shows that the average price per cigarette of a machine-vended package of cigarettes is just over 30 cents. Similar-sized packages of cigarettes sell for an average price per cigarette of just under 26

cents in stores in the areas surveyed.

Consequently, prices serve as a deterrent to teenagers. They just don't buy cigarettes through a vending machine. The chances are greater that a teenager is buying his or her cigarettes at a corner store or out of the trunk of a car than through a vending machine.

The Canadian Automatic Merchandising Association wants to assure this committee that it supports the spirit and intent of Bill 119, which is to prevent, or at least discourage, young people from starting to smoke. This association also agrees with the proposal in Bill 119 to raise the legal smoking age to 19. We ask, however, that the government follow the federal government's guidelines with regard to the sale of cigarettes through vending machines.

The planned federal regulation governing the sale of cigarettes through vending machines requires that the placement of cigarette vending machines be limited to bars, taverns or other similar beverage rooms where access in Ontario is limited to persons 19 years of age and older. It also requires that every cigarette vending machine in such locations be located in a place so that direct supervision of the vending machine is maintained by the person in charge of the bar at all times while the bar is open for business, and be situated in the bar so that it's farther away than five metres from any entrance to the bar. With the exception of Nova Scotia, the trend in the rest of the provinces appears to be to follow the federal guidelines. We ask that Ontario do the same.

The majority of our members who are still selling cigarettes through vending machines already have their machines exclusively in bars, taverns or similar beverage rooms. By following the federal government guidelines on this issue, the committee has the power to ensure the livelihood of some of Ontario's struggling but optimistic small businessmen and women.

At the very least, we ask this committee to provide our members and all other owners and operators of cigarette vending machines in Ontario one year to adjust their businesses to accommodate the new law and in accordance with Bill C-111, if necessary, should it come into effect as planned on July 1, 1994.

Bill 119 provides pharmacies a full year from the date of proclamation to adjust their businesses. However, Bill 119 provides only three months to owners and operators of cigarette vending machines. Pharmacies clearly have a diversified product line. They do not rely, to any degree, on the sale of cigarettes to survive. The same is not true for the small businessmen and women who own and operate cigarette vending machines.

To reiterate, the negative economic impact of Bill 119 will be deeply felt by those engaged in the sale of cigarettes through vending machines in Ontario. Therefore, we ask once again that the committee recommend amendments to Bill 119 that will allow cigarette vending machines to be placed under direct supervision in bars, taverns or similar beverage rooms.

If this is not possible, we request that the committee recommend amendments to Bill 119 that will allow those engaged in the sale of cigarettes through vending



machines the same consideration that is being offered to pharmacies with respect to the time line for conforming to this legislation with respect to the restriction governing the federal law.

I would like at this time to invite the committee to ask any questions that you might have about the effects of Bill 119 and its direct effect on our industry. I would, however, like to ask the committee a few questions after that, if I may.

**The Chair:** Did you want to ask your questions first?

**Mr Orriss:** If that's your preference.

**The Chair:** I can't say that the committee will be able to necessarily answer your questions any more than you may be able to answer every individual committee member's, but—

**Mr Orriss:** As a result of the proposed legislation, we've had many discussions with all members of our industry and we've had questions come back to us and frankly we don't have the answers. We're hoping that at this time, or at least when the law is set, it will be taken into account and we can have a response for these.

The law obviously will have serious repercussions on the financial stability of businesses in Ontario that sell cigarettes through vending machines. In some cases, people will lose their businesses altogether and those who don't face bankruptcy are certainly going to face a very dramatic decrease in their profitability and their operating position.

What we would like to know is, does the government plan to compensate these people in any way for lost income? Does the government plan to compensate these people in any way for the cost of adjusting their style of business? Does the government plan to compensate these people in any way for the cost of disposing of these useless machines? Does the government plan to compensate these people in any way for the substantial loss of capital investment that would be created through this bill in making the equipment obsolete?

The other question I had pertains to precedence of federal or provincial law. Obviously, with Bill C-111 taking effect, we anticipate, on July 1, if the Ontario government goes ahead with the ban of cigarette vending machines but gives vending operators a year to comply with the law, will these operators have to abide by the federal law if it comes into effect on July 1? In other words, if operators are given a year to close out their cigarette vending machine businesses, will they still have to remove their machines from every location except bars, taverns or other similar beverage rooms by July 1 or does the provincial law take precedence over the federal law in this case?

1540

**The Chair:** I'm going to ask the parliamentary assistant, who is carrying the bill for the government, to respond to those questions. As you understand, those are part of our record, they're in Hansard, so we all have those questions as well.

**Mr O'Connor:** Some very pertinent questions. First of all, the rationale behind having the total ban in Ontario: Contrary to what your brief has pointed out,

licensed premises in Ontario are accessible by young people. Of course the thrust of the legislation is the young people. The federal government ban is going to be quite comprehensive as well. It just doesn't go as far. Because licensed premises are accessible for young people, that's why we've gone that one step further.

Is the federal government planning on compensating the owners of vending machines right now?

**Ms Davenport:** Not to my knowledge. I'm certainly not aware of any precedent for that.

**Mr O'Connor:** The rationale behind the three months is that three months, from what we can gather, and maybe you can enlighten the committee, would be about the length of time it would take for your stock, the product you're selling, to be used up. We're certainly hoping to hear what you have to say as well.

**Mr Runstedler:** I would ask then, if it's three months for vending, what is the rationale of one year for the drugstores? Is that the same rationale, a year to use up their inventory?

**Mr O'Connor:** Partially, yes, that would be the case.

**Mr Runstedler:** I think if you looked at their records you'd find their stock turns are less than a month, and their year is quite substantial compared to our three months.

**Mr O'Connor:** We have heard from this committee that they'd like to see their time shortened to three months as well. Thank you for that input.

**Mr Orriss:** One of the concerns we had in that time frame is the logistics of bringing in to a warehouse, in some cases, hundreds of machines that are rendered totally obsolete. There is no market for them. We're talking about millions of dollars' worth of vending machines.

We could scrap them. I know from experience if I take a scrapped cigarette machine to the yard, I get between \$1 and \$1.50 for that piece of equipment. Obviously that's not an answer to us, to pull them back in in hopes of doing something else. There's really no other use for the machine, but even during that time we're going to have to warehouse, in some cases, individual operators, hundreds of vending machines. There is no after-market. They are obsolete. Three months doesn't give us time to bring those machines in and make arrangements for that.

**Mr O'Connor:** You'll still have to comply with the federal legislation in which the ban does take effect July 1.

**Mr Runstedler:** Which means a small percentage of the industry, because taverns aren't involved with the federal law. In taverns, licensed premises, you can still leave the machines, you're just pulling them out of lobbies or public areas.

**Ms Davenport:** Workplaces etc.

The other consideration with regard to this is the fact that a lot of these people will have to adjust their businesses. They'll have to try and source out new markets for their products. Three months is not enough time to concentrate on getting rid of the machinery and taking it out of the places it's at, let alone revising a business plan



and sort of readjusting one's strategy on how they're going to cope and survive.

The important thing to bear in mind is that these people are small business owners and not people who get unemployment insurance. They don't have some of the social safety nets available to them if and when their businesses fail. For that reason, if not any other reason, they should be given enough time to try and continue to survive and to eke out some kind of viable existence for themselves.

**The Chair:** I'm going to move on to questions now, but those are very useful questions for the committee as we think about the bill and as we go forward with it. Some of that may come back up again in the questions anyway.

**Mr Arnott:** You made a very compelling case for compensation if indeed this bill goes through, and you can be assured that the Conservative caucus will support you in that. What is it, \$800 million a year that the government receives in tax revenue? Certainly a portion of that should be allocated towards a generous compensation program.

If this bill does go through, it's very clear that many of the companies in your industry will be literally wiped out. One day it's legal and the next day it's totally illegal. I'm not sure, if I were faced with that prospect, what I'd do, but obviously you're out of business. If it's government edict or government legislation that is having that effect, you have a very good case and I would hope the government would give serious consideration to that.

Your suggestion that your machines continue to be available in licensed establishments, for example, is consistent with what the Ontario Restaurant Association has told us, so you've got an ally there. Your point with respect to how much time is given to phase out the industry, if indeed the bill goes through, is that it should be consistent with what the pharmacists receive. Again, you've got a very good case with respect to that. I can't see any rationale for giving the pharmacists a longer time to phase out than your industry, especially when your industry, in many cases, will be absolutely devastated, whereas it's been suggested that some pharmacies may close, but I don't think anyone's suggested that every pharmacy in Ontario will close as a result of Bill 119.

**Mr Wessinger:** I'd just like a little bit of clarification about your numbers. I gather that basically you have two companies that are solely in the business of cigarette vending machines which you represent. Is that correct?

**Mr Orriss:** No, sir. We represent 21 operating companies in the province.

**Mr Wessinger:** That is part of their business, but for two of those 21 it's their sole business, because you indicate two of them would go out of business entirely. I'm just taking that as a correct assumption.

**Mr Orriss:** Yes, that's right, one being a very small operator who has no other types of vending machines at all. He will cease to exist as of July 1.

**Mr Wessinger:** You say there are 3,363 cigarette vending machines in Ontario. I know many of these are in motels and in halls and so forth, but do you have any

statistics to indicate how many of those would be rendered inoperable as a result of the federal legislation? You may not have it exactly, but could you give it to me approximately?

**Mr Orriss:** Approximately half. According to the Statistics Canada report of 1991, 47% of any machines were in the classification of taverns, bars and licensed establishments.

**Mr Wessinger:** Right. As I understand it, those 47% that would still be permitted under the federal legislation, you would like to have an extension for those because I gather the federal legislation is going to prohibit them in the other locations as of July.

**Mr Orriss:** For the 53% that are not located in licensed establishments? We are prepared to accept the federal law as it's being proposed. It's our hope to allow the people operating vending machines to be able to do so, albeit on a somewhat narrower scale than they did before.

**Mr Wessinger:** So you're asking for a year for those that are permitted to continue to be operated before you have to cease operations. I just want to know what they apply to.

**Mr Runstedler:** No. The federal law? We agree with the federal law, as an association. We're not arguing with preventing children from smoking. The federal law allows cigarettes in licensed premises. That's all we're asking, that the Ontario government do the same as the BC government has just done, that the Manitoba government is considering, that you just follow the federal law. Instead of having two different laws, we'd have one law banning them in public places where half of 1% of the total business is being purchased, which you're saying that all the children are buying. We agree with you: Get it out of public places.

**Ms Davenport:** And at the very least, if section 7 of Bill 119 goes through as it is currently written, then we're asking that we have at least a year, and during that period, I guess from July 1, we'll have to remove them from every other place but the bars, taverns etc.

**Mr Wessinger:** That's what I thought, that's what I wanted to understand. Thank you.

1550

**Mrs Haslam:** Of 21 operating companies, two sell tobacco only. In the other 19 operating companies, what percentage of their machines are for tobacco? Obviously there are vending machines for sandwiches and pop and juice. Do they know the percentage of tobacco vending machines in the other operating companies?

**Ms Davenport:** It varies from company to company. These are all individual businesses, so the percentage of their business dedicated to cigarette vending machines as opposed to sandwiches and pop and what not varies in each of those companies, so it would be really difficult to come up with a hard number.

**Mrs Haslam:** Is it impossible to take the tobacco vending machines and change them technically to do the sandwiches? When you go into the highway pull-offs you have chips. They're all different sizes.

**Ms Davenport:** That's an excellent question.

**Mrs Haslam:** So can you accommodate those machines?

**Mr Runstedler:** No, the tobacco machines are set up as such that the columns are so small for a small 20-pack or 25-pack, you cannot convert them to chips. You can convert them to selling cigarette lighters, but if you're going to ban cigarettes there's not much point in selling cigarette lighters. It's just small things. It just wouldn't warrant all the conversion. You could go buy a new machine. It's too costly.

**Mr McGuinty:** You've raised some very good questions and I look forward to hearing the government's response to them. What you've done here is force us to stare into the face of one of the downsides associated with Bill 119. Some people would have us believe that it represents motherhood and that there are no downsides, but I disagree. With every piece of legislation there are good parts and bad parts. If we're going to go ahead with this, and I assume we are going to go ahead with it, we have to recognize that some people are going to get hurt. It's incumbent on the government, first of all, to make that recognition, to acknowledge that it's doing it in the broader public interest, that it's going to be putting people out of work, and to consider compensation.

I introduced a private member's bill which would have attacked smoking in so far as it related to children. I looked at some of the experiences in the States. New York City in fact passed a bylaw which is the same as the feds are considering now. After that met with some success, it was adopted by New York state; a number of other states have taken the same approach.

The idea behind Bill 119, the primary thrust, is to make it tougher for kids to start, and everybody agrees with that. I'm not sure, and I haven't heard from the government on this, why we can't allow these vending machines to continue in age-restricted licensed establishments. If it's not a law, if I can go into an age-restricted licensed establishment in this province without being asked for identification, then let's include that; let's incorporate it as an amendment to Bill 119 saying you can have vending machines in licensed establishments but only where you check for ID at the door. Would you have any problem with that?

**Mr Orriss:** No, sir, I wouldn't. If I could point out an interesting statistic, obviously the primary thrust of the bill is to stop smoking before it starts. The hope is also to reduce smoking in the population. A statistic from the Addiction Research Foundation shows that teenagers between 15 and 19 represent just 6% of the smoking population of Ontario. To put that further in perspective, with the vending industry having less than three quarters of 1%, I don't know how many zeroes you have on your calculator, but multiply that again with the number of underage teenagers who go into licensed establishments and you're creating a problem where there isn't one now. It doesn't make sense to legislate where there is no need for legislation.

**Mr Ron Eddy (Brant-Haldimand):** I had an inquiry regarding the use of vending machines. It would seem to me, and I was surprised at how much they are used, that with such a large underground economy where in some

areas of the province the sale of illicit cigarettes is very, very high, and in view of the fact that the price in the vending machine is a bit higher, do you find a tremendously large decrease in the use of the vending machines? I'm surprised they're used at all, because of the contraband cigarettes, which are growing every day, completely out of control.

**Mr Runstedler:** In answer to your question, the trend of the last few years has been down, in terms of volume per unit. But the big thing is you'll notice that the vending industry is a convenience industry. It's in an area, a pub or a tavern, where if you run out of cigarettes and you're having a beer, you don't want to be running to the contraband corner. "I want my pack right now," so he walks over and buys his cigarettes to finish off his evening. But we are higher-priced. Teenagers today are very financially astute, let me tell you, and they aren't going to be paying 30 to 40 cents a pack more when they know they can get it at the corner store for a lot less.

**The Chair:** Thank you very much for coming before the committee today and for your presentation. We appreciate it.

The parliamentary assistant has a point he would like to make.

**Mr O'Connor:** As I had stated when we had the people before us making their presentation, the reason our legislation includes a total ban is because licensed premises in the province of Ontario are open and accessible to people who are under the age of majority. That is the reason behind that. I certainly appreciate them coming forward and giving us their economic picture. The rationale is that licensed premises in Ontario are accessible by young people.

**The Chair:** As I said to the parliamentary assistant, we're not, at this point, going to get into a long debate about this. These are differences of opinion, perhaps. Mr Wilson, a comment, and Ms O'Neill, a comment, and then we really must move on.

**Mr Jim Wilson:** To the parliamentary assistant, the federal government knew that when it put its law forward. Secondly, what I'd like an explanation for is licensed premises. Minors are supervised with respect to alcohol; in other words, you can't serve alcohol to a minor. In those same premises where we entrust that, why can't we say that you have to watch the vending machine too? As Mr McGuinty and other jurisdictions have pointed out, you put it so many feet within the bar area or supervised area and charge them with that responsibility too. Obviously, you considered that. What was the outcome of that discussion?

**Mr O'Connor:** The important element is that the vending machine doesn't have the same ability to question the person putting in the loonies to buy those cigarettes: "Are you 19 years old?" The vending machine doesn't have that capability.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** For the record, can Mr O'Connor, because not everyone is not familiar with the same discussions he has had, give some examples of the licensed premises being open to minors? Could you just expand a little?



**Mr O'Connor:** Sure. A family restaurant like O'Toole's is a licensed premise. I don't want to name names of establishments, but you can relate to licensed premises. Quite often you will take your family out to—

**Mr Wessenger:** Swiss Chalet.

**Mr O'Connor:** Yes, Swiss Chalet. There are a number, but I don't want to name premises. You can relate to any one.

**Mrs O'Neill:** I think that's important for the record.  
1600

#### NON-SMOKERS' RIGHTS ASSOCIATION

**Mr Garfield Mahood:** Mr Chairman and members of the committee, my name is Garfield Mahood and I'm the executive director of the Non-Smokers' Rights Association. On my right is David Sweanor, the senior legal counsel for the Non-Smokers' Rights Association.

By way of introduction, I'd just like to let the committee know a little bit about who we are. We operate a non-profit health advocacy organization which has offices in both Ottawa and Toronto. We have a staff of close to 10 people.

I think it's fair to say that our organization led the national campaign for the Tobacco Products Control Act. We played a major role in the passage of the federal Non-smokers' Health Act. I think it's also fair to say that we led the initiative for the new federal warnings which are coming on cigarette packages later this year. It's also fair to say that David Sweanor, our legal counsel, who is an acknowledged expert in tobacco taxation, has been principally responsible in this country for the world-precedent-setting declines in tobacco consumption. Taxation policy and price have been the major factor in the world-precedent-setting declines. That's our background on the organization. We've been in business for about 20 years.

After the introduction, I'd begin by saying that I'd like to praise the government and the minister for the legislation before the committee. We think there are some precedent-setting features in the legislation. It's not all we want; there are certainly areas for improvement, but considering the fact that we've never had a serious tobacco bill before the province of Ontario at any time in the history of the province, this government deserves a lot of praise. I think that should be remembered, and we want to go on record as pointing that out.

There is an even greater need for this legislation given the developments in recent days. You saw the full-page ad in the Globe and Mail yesterday, I'm sure. The threatened tax rollback really has created a situation where, if anything, the province is going to have to go further than it intended when this legislation was introduced.

To explain the seriousness of recent developments, because David Sweanor has been at the heart of this, I'm going to ask David why the tax rollback is such a threat to the health of the kids of Ontario.

**Mr David Sweanor:** I think there are two things that are important to this committee in looking at this legislation. One, as Gar says, price has been the single most successful tool used to date in reducing consumption. It has done a very good job. We now do have a serious

problem of smuggling. We've also seen the possibility of the federal government reacting to that, rather than dealing with the contraband, rather than putting up the price of the stuff that's being sent back and forth across the border, by looking at reducing Canadian taxes to a US level.

If that were to happen, the estimates, based on the work of epidemiologists and economists, given the relationship between price and demand, we'd expect at least 800,000 additional smokers in this country. A large portion of that market would be kids. They're the most price-sensitive. It would eventually translate into somewhere in the range of a quarter of a million additional deaths. It would deprive governments of revenue in the range of \$2 billion to \$3 billion. It would add an equal amount to annual health bills eventually because of the toll of the use, and it would reward misbehaviour on the part of the tobacco companies and on the part of the smugglers.

I think the real lesson in this for Ontario is something we knew all along in working in the federal system: that if we're looking to deal with health problems, with public issues in this province, we don't have total control of what goes on. The federal government can make decisions, as crazy as they might be, that end up affecting the health and the wellbeing of the people in this province.

That's why when we're looking at not only what Ontario can do to bring some sanity to Ottawa, our home town, we could also look at what we can do with this type of legislation to make sure we get the best thing we can, because we really at this point cannot count on the federal government to protect the people of this province, particularly the kids of this province.

**Mr Mahood:** Just so you understand the figures David has just used, a future mortality of 250,000 deaths, revenue losses for governments at various levels in this country in excess of \$2 billion a year, there is a document that the clerk will distribute from Harvard University professor Robert Allen, which was prepared for the national news conference, which does the assessment of the death rates and the financial impact. He's a visiting professor of economics at Harvard, and this document will underpin what David is saying.

**Mr Sweanor:** What health and medical organizations are looking for in trying to develop good policy in the area of tobacco is really taking the comprehensive plans that have been developed by groups like the World Health Organization and the International Union Against Cancer and others, and implement them. As Sir George Young, the former assistant health secretary in the UK, has been quoted as saying, the major advances in public health are not made by incision on the operating table but rather by decision at the cabinet table. It's exactly the situation we're in. The big advances we've had in public health in the history of this province, this country, are things like water purification and sewage treatment, housing standards and workplace safety. We're finally extending that now to the product that's by far and away our biggest cause of preventable death.

When we look at what these comprehensive plans entail—and they're usually very, very comprehensive—it



really comes down to three general areas. One is the whole issue of accessibility. How accessible is the product, and how can we ensure that the accessibility of that product more adequately reflects the harm inherent in its use? Those are such things as who can buy it, the sales to kids; when they can buy it; where they can buy it; how affordable it is.

The second issue is informed consent. How can we make sure we give people sufficient information so that they can make informed decisions about their own health? Those are such things as the health warnings, which this legislation would allow the province to have; health education campaigns; forcing tobacco companies to tell what additives are in their product. Give people the information they need.

The third area is protection of others to ensure that when the product is being used, it's being used in a way that isn't going to harm other people. The legislation we're considering now clearly looks at all of those areas, and there are some very good precedents in it that would be important, not only for the 10 million people here and the much larger number in the entire country but the fact that many other countries are looking to Canada for examples of what they should be doing in preventive medicine, specifically on tobacco. We're very aware of that. Whatever we adopt here will be used by other jurisdictions, and it has a tremendous possibility of affecting future mortality and morbidity trends far beyond our borders.

**Mr Mahood:** We want to come here today and express very strong support for many of the principles advanced by the Ontario Campaign for Action on Tobacco. They've identified four critical areas for attention with this legislation.

First of all, because of the tax rollback threat, this in fact throws a greater responsibility on the province to bring forward something that works. Without question, in our view, a licensing system is one of those four areas that the Ontario campaign identified as being critical to the success of the legislation. We've agreed with government officials that if statutory prohibitions, as opposed to a licensing system, were enforced, a statutory prohibition could work, the same as licensing will work if it's enforced.

The beauty of the licensing system is the fact that you have a self-financing system with a group of people who have a vested interest in making it work, and you have a framework already in existence here in the province whereby a licensing system could come forward.

In tight financial times we're afraid that whatever would be required in order to make a statutory prohibition work may not be there. It may be that at some point in the future—maybe the committee wants to look at it now, but certainly there should be some kind of report on how effective the enforcement process is going, because we suspect we may have to come back and revisit the whole issue of licensing in order to ensure that there is a system out there that in fact is blocking the sales.

1610

Another area we identified as absolutely critical for the

success of this legislation is getting rid of the double messages sent to the community when health professionals sell tobacco. This gets us into the whole area of pharmacy.

I know you've probably heard more than you ever want to hear about pharmacy today. Well, let me tell you that what you've heard today will be addressed. We will address it in a major way. It may not be addressed here today. We've had a chance to take a superficial look at what was presented. You were talking to the tobacco industry today, but like a lot of tobacco industry material, when you examine it closely, it doesn't stand up to scrutiny.

Now, let me just make a real quick reference to a couple of things which will be addressed: the Coopers and Lybrand study. It's amazing. You have a group of people who come before you and predict disaster for pharmacies. Isn't it interesting that the major chain in this province which is leading the fight is Shoppers Drug Mart, entirely owned by Imasco Ltd, the biggest tobacco company in the country? You had before you David Bloom, who just happens to sit on the Imasco board, and he's predicting disaster.

Isn't it curious that Big V Pharmacy, which is the independent pharmacy—it's the second-largest chain in the province—isn't going to oppose the legislation? In fact what we've got is a situation that Big V is so incompetent in terms of its operating policies and its work in the community that it doesn't know that it is going to take a nosedive and all these pharmacies in western Ontario are going to close.

Isn't it curious that the 18-store Dell Pharmacy chain has voluntarily taken it out of their chains? Somehow or other, Dell is also going to take a dive and people are going to be out on the street.

We're going to address that, because of course common sense tells you that it's lunacy. In fact, it just doesn't make sense. When something doesn't make sense, there's usually a little bit of mumbo-jumbo when the industry brings forward its consultants and builds these supposed cases.

Shoppers Drug Mart claims they're normal retailers. Well, my God, what is their corporate theme? What are they promoting? "Everything you want in a drugstore." They don't say, "Everything you want in a retail store." They say, "Everything you want in a drugstore." Isn't it interesting that they would know the difference and they would know enough about their customers to understand that their customers and the people out there whom they're trying to attract to their stores know very well the difference between a drugstore and a normal retail outlet?

We're going to have lots to say about Shoppers Drug Mart. This is going to be a very interesting campaign that develops. They simply cannot get involved in the business and have any credibility as health professionals.

If the clerk would be kind enough to pass out the pharmacy brochure, this is a sufficiently important brochure that we want to draw attention to a couple of things in here. You'll notice the photo right in the centre of the brochure with the Shoppers Drug Mart promotions. I can

tell you, these guys know how to promote cigarettes.

It's also curious that when the bill was announced, all of a sudden, the Shoppers Drug Mart promotions around the province, with the big red cigarette signs, curiously all came down. In a matter of days, they disappeared. All the beautiful photographs that we've got of Shoppers Drug Mart—we can't get them any more, because Shoppers knew that the spotlight would be on Shoppers Drug Mart once the legislation was tabled. So all these wonderful promotions that Shoppers was engaged in all came down. But unfortunately for Shoppers, we've got lots of red and white cigarette promotions in our photo file, and we'll be tabling some of these.

In the centre, you've got addenda, and one is here from Medis Ontario, one of the wholesale firms. Listen to what they say right in the middle: "All purchases, including drop shipments, contribute to your volume rebate plateau. Just a few extra cases of tobacco per week can double your volume rebate on all pharmaceuticals." Of course Shoppers Drug Mart says: "We're not in the business of promoting tobacco. This is all aboveboard. We're just supplying demand." Don't believe it. We'll deal with the nonsense later.

Plain packaging, a third critical area that we're going to be talking about: There's now research—

**Mr Perruzza:** Are you listening, Jim?

**Mr Mahood:** The Ontario Campaign for Action on Tobacco and our organization have identified plain packaging as an absolutely critical area of reform. This legislation is valuable because it allows the province to take control of the packaging, which is absolutely critical.

Why is that essential? You want to see what a tobacco industry can do when it engages in its more repugnant and irresponsible behaviour. This is a little white cigarette package designed for little girls, with rainbows on the covers. It's like a perfume package. Here's one with candy stripes. This is Newport. This is what we would have in this country if we didn't have a Tobacco Products Control Act. I'll pass these things around, because they are really repugnant. This is Vogue. This is what happens when they target little girls. This is Capri.

It's all freedom, it's all independence and it's all designed to say to a little 12-year-old kid, a little girl: "Guess what? This can't be harmful because if it were harmful, they'd never allow the products to be packaged like this."

Here's a plain cigarette package. This is what a generic package or a plain cigarette package might look like. Why is that so important? I'll tell you why it's so important: There are two billion cigarette packages sold every year in this country, and 25 to 30 times a day they come out of shirt pockets and purses; they sit on the dash or the seat of the car and they come out 25 to 30 times a day, which makes total viewings of somewhere in the neighbourhood of 50 billion viewings a year.

There's another powerful part of it. Not only does it swamp all the other advertisements because these are package advertisements, every time a child sees it, it comes with an implicit endorsement from a parent, an adult, a significant other. The implicit message is that it

can't be as dangerous as health professionals say it is because if it were, mother and dad wouldn't be using the product.

If you want to deal with tobacco advertising and promotion and really protect kids, you have to deal with the main promotional tool the industry has always had. It's never changed; this has been it. When you go to plain packaging, you solve a lot of problems. If you're trying to send a message to kids that it's dangerous, as soon as you put it in plain packages, you say to kids, "This product is so different, so dangerous, that we can't allow it to be packaged in those normal beautiful packages." The second thing you do is that you prevent the industry from using sponsorships to get around the advertising ban, because once you're in a plain package, you have no trademarks, no colours, no design to link back to.

If you're concerned about smuggling, one of the keys to stopping smuggling is identification of the smuggled package from the duty-paid domestic package. As soon as you go to plain packaging, guess what? You can't hide the smuggled package any more.

Virtually everything you do in David's comprehensive plan is either exceeded by or equalled by this measure. It's absolutely critical. We're pushing that very hard.

Finally, on the question of environmental tobacco smoke, enough has not been said about that. The environmental tobacco smoke sections in this act have to be strengthened. The reason for this is that the United States Environmental Protection Agency just within the last year identified environmental tobacco smoke as a group A known human carcinogen. If the clerk would pass these brochures around, this will give you more information than you ever wanted to know about environmental tobacco smoke.

A group A carcinogen: There are only 10 or 12 listed by the Environmental Protection Agency in the United States. That list includes asbestos, benzene, arsenic, vinyl chloride etc. You cannot have a group A carcinogen going into your public areas and your workplaces, so we're going to recommend that you strengthen that section on the environmental tobacco smoke in public areas, and we're going to also recommend that you make a recommendation that the Ministry of Labour get going on consultations and bring forward a separate bill to deal with this problem of smoking in the workplace.

There are only two solutions that make any sense when you're dealing with this problem: You've either got to have no smoking in an indoor environment, or if you allow smoking, it's got to be confined to separately vented lounges exhausted directly to the out-of-doors.

Having said that, those are four key areas. Obviously, we want to support the spitting tobacco recommendation. We want to support the vending machine ban, because otherwise the sales will go from the places that have been closed off and they'll switch to vending machines and you'll have a bigger problem two or three years from now.

Those are general things I wanted to talk about. David will talk about the specifics of the legislation.



**Mr Sweanor:** Just a few examples, because I'm sure you're hearing this from lots of organizations: As to section 6, which talks about the signs that would have to appear at retail, it says you can't "sell tobacco at retail unless signs bearing health warnings and referring to the prohibitions...are posted."

I think you should expand that. You can use the same sort of language that's used in clause 5(b) above that, something along the lines of "health warnings and other information" or "other health information." For instance, having a toll-free number for people to call to get information to help them quit is not a health warning; it's health information. You wouldn't want to prevent the province from having the ability to do that if, hopefully, at some point we're able to do that. You want to help people, once they're aware of the health information, to know what they can do to deal with the problems.

Also, in terms of inducements to sell, when we look at the packaging requirements in section 5 and the signage requirements in section 6, I think we should expand that so you have the ability to require by way of regulation some sort of health information on inducements to sell tobacco, including tobacco company sponsorships.

Right now we have the problem that a kid can walk into a variety store and be surrounded by what are in effect lifestyle advertisements, which tobacco companies say they can get away with under the federal legislation because it'll be saying "Players Inc" or "Export A Ltd" rather than "Players" or "Export A." I don't think they're fooling anybody in terms of what the real intent of that is.

Ontario could either make it a condition of sale that those things not be allowed at point of retail, or perhaps best yet, on the idea of let's have more information, let's get the facts out to people, require that any such messages, whether at retail or anywhere else in the province, must have such health information as would be prescribed by way of regulation, so that whenever somebody sees that information, the lifestyle inducement to use tobacco, you're also getting some health information. Let people make an informed decision.

When we're looking at the issue of vending machines, certainly at the idea of saying that no kid should be able to access tobacco without there being a human intermediary, the same philosophy.

We should look at the issue of self-service displays and countertop displays. An awful lot of stores in this province still have those countertop displays right next to the candy. A lot of them have the little 15-cigarette kiddie packs in them. It's very difficult to tell the merchant you have to check for ID if that kid's already got the cigarettes in his hands. It's also very difficult to check for ID if the kid has left the store with the cigarettes without paying for them. They're an inducement to shoplift. I'm aware of a study from the States that said the manufacturers pay retailers enough to have those countertop displays that even if every single package was shoplifted twice, they would make money.

We don't want to have any inducements for kids to shoplift cigarettes. We don't want to put merchants at a disadvantage. How do you ask for ID, how do you refuse

a sale, if the kid already has the cigarettes in his or her hand? Getting rid of self-service displays and countertop displays makes it easier for a merchant to make sure they've done their duty under law and it makes it harder for somebody to simply steal the tobacco. It makes a lot of sense.

To keep this very simple in terms of various possible amendments you could look at, another one is on section 12 that deals with aboriginal use of tobacco. We should ensure that when that is done, that there be a basic requirement that all reasonable measures are taken to ensure that no one is involuntarily exposed to the tobacco smoke. Granted that there are reasons we would want to ensure that natives can engage in activities that are important to them for cultural, spiritual reasons, there's no reason to allow a situation that would allow this to happen in a way that could be harmful to someone else's health.

I know it's a little flippant, but it's like saying that those of us with some Scottish background might feel it's very important for cultural reasons to throw hammers, but we do have limits in terms of where we can throw them. I think we want to make sure this is something that doesn't cause more problems. It's just basic John Stuart Mill: Engage in activity that is not going to be harmful to the people around you. Those are some very quick comments on the legislation.

**Mr Mahood:** Our feeling—we expressed this before—is that the word "cultural," because it is so broad, means virtually everything. Certainly "spiritual" and "spirituality," with aboriginal people being protected with respect to spiritual ceremonies, and wherever tobacco is used in that sense, we support that, but there are a lot of things going on with respect to tobacco that could be classified as cultural and that gives a major loophole that we want to close off with respect to that particular clause.

We will have a written submission before the committee in a few days, and if you have questions, we invite them.

**The Chair:** There are probably questions that would go on for some time. I'm afraid time is a bit short, but I want to try to work in a question from each caucus.

**Mr White:** We've had a great deal of argument. Every person who's come in front of us, from whatever background or stance, has said that they oppose the smoking of cigarettes and the inducements to adolescents to smoke cigarettes. Yet somehow, some of these people who have come in front of us make a great deal of money from that very habit.

Many of them have said there are going to be job losses, pharmacies closing, their businesses being affected etc. Personally, in regard to the pharmacy, that is not an issue about stopping access to the sale of cigarettes, but rather limiting it relative to a health care profession.

Aside from the 40,000 deaths in this country and the innumerable cases of asthma, emphysema etc, do we have any idea of what the economic cost of this habit is that we could use to buttress against the argument that there will be jobs lost?



**Mr Sweanor:** The estimate that the federal health department has now I believe is \$15.9 billion as a loss because of tobacco consumption. There's also a problem with that because there are those of us who can remember philosophy of science from undergrad days, saying that scientists are very good at measuring the things they know how to measure and equally good at ignoring the things they don't know how to measure. We're not including in that a heck of lot.

You could put an economic number on it if you did a heck of a lot of work, such as you die early and leave young kids behind you and the chance of them having higher education goes down, the chances of them being involved in a social support system goes up. Some things you simply cannot measure. What was the value to any of us of having a grandparent? So it's huge.

When we look at the jobs, it's worth noting that direct employment in the tobacco industry is under 10,000 people. The annual death toll is over 40,000. If that's a good idea in terms of jobs, civil war is even better.

**Mr White:** You're saying that at a very conservative level—or at a very cautious, low estimate—we're talking of \$15.9 billion, which could of course build a great deal of highways and create a number of jobs in that regard.

**Mr Mahood:** You can pay an awful lot of people with that amount of money.

The tobacco industry, through Shoppers Drug Mart, is in a bit of a bind. They're claiming that they are going to lose all this business and that it represents all these jobs, and on the other hand they're claiming that it won't reduce any consumption. They can't have it both ways. If it's not reducing any consumption, that means the jobs are simply going to shift to other retailers, so there's not going to be a net loss. They're wrong on this, but the fact is that's what they're claiming, that they are not going to reduce any consumption, which means the jobs are going to appear somewhere else.

The reality is that it is going to reduce consumption, in which case there's going to be a health benefit. It is the dilemma that was addressed in the major economic report that Brenda Mitchell and John Garcia and other members of the Ministry of Health staff have in their possession called *The False Dilemma*.

The reality is you cannot come forward and purport that you want to address a major health problem and wind down an industry—that's government policy both at the federal and provincial level—and somehow or other maintain all the jobs in the industry. You have to come to grips with that. The comforting thing is that because so many people are addicted, the wind-down is going to be over such a long period of time that it will be the slowest phase-out in the history of business.

You're not going to have the big problem that the industry wants you to believe you're going to have. It's going to be handled by attrition. But the fact is that you cannot deal with the epidemic and keep the industry there at the same time unless it's there as a monument to all the deaths in the past.

1630

**Mr McGuinty:** David, I can sympathize with or

understand some of the role you're playing. One of my first jobs when I became a lawyer was to act as volunteer legal counsel for the Ottawa Non-Smokers' Rights Association. I hope they're paying you more than I got paid back in those days.

I appreciated the comments you made because I had an opportunity to review the Hansard hearings for the committee dealing with the contraband problem, with the underground economy.

But I've got a new job now—

*Interjection.*

**Mr McGuinty:** I'm still not getting paid.

To be very frank with you, I fully expect that the pharmacists are going to tell us that they're going to take a tremendous hit as a result of this legislation. I fully expect too that you will tell me that they're going to take virtually no hit. I suspect, because I'm required to weigh these matters, that the truth lies somewhere in the middle. I'm just wondering if you can give me a number so that when we go ahead with Bill 119, as we undoubtedly will, we'll have an understanding of the implications in terms of job losses.

**Mr Sweanor:** I can deal with some of that. If you look at the raw numbers, and we can try to work something out, there would probably be some jobs lost. But in terms of what we've experienced to date on any health legislation in this province, including things like when we got rid of billboard advertising and the claims we heard at the time that virtually everybody would be bankrupt and unemployed, in fact they think of other things to do.

What we've seen with an awful lot of businesses in the sorts of changes we've gone through is that as sales of one product go down, people don't leave the counter space bare. They think of what else can be there. If we look at many of the businesses in Ottawa south, at the way those businesses have changed, the people who were selling a heck of a lot of cigarettes are now more into renting videos or whatever else. So they do change.

The other thing to keep in mind is that when the Shoppers Drug Marts of the world aren't selling cigarettes, to the extent that all those people aren't simply going to quit, some of those people are buying them elsewhere. It means, to again use our home neighbourhood, that you're switching from a Shoppers Drug Mart to, say, a Mary's Variety. The fact is the jobs simply move from one place to the other.

There's the other thing to recognize, and that's professional responsibility, which is exactly what we face in our own profession. We could not make the case as lawyers that many of us are borrowing money from clients and dipping into our trust funds but if you prevented us from doing that by way of legislation, a lot of us would have to lay off our legal secretaries and perhaps go bankrupt ourselves. The fact is we've got ethical obligations.

Pharmacists, having been given a monopoly over a particular area of the health care system, are being given something by society the way we as a legal profession are given something by society: a monopoly over a particular area of endeavour. With that come ethical responsibilities in terms of how we are to act. In this

case, when their own ethical code says that you would never knowingly sell any drug that does not have therapeutic benefits, that sounds to me a lot like our ethical code and what it's telling us to do.

In this case, when the professional body that oversees the pharmacists said, "Yes, this should be gone, but we can't do it voluntarily because we have the problem that the biggest chain of pharmacies is owned by our biggest tobacco company," it's a bit of a conundrum. I think that's where the government would have to move in.

You will see jobs shift from one place to another, but whether a clerk is working at a Shoppers Drug Mart or a Mary's Variety probably doesn't make a heck of a lot of difference to overall employment. What will make more of a difference is the consistent message to kids that if you're a health professional, you're not knowingly selling our leading cause of preventable death.

**Mr Jim Wilson:** I think we're allies on many of the sections in this legislation. However, I want to make a statement about my understanding of Big V. First of all, I think it's the third-largest chain in Ontario. Correct me if I'm wrong. My understanding of president Norm Puhl's position is that he would agree with the Ontario Chain Drug Store Association, which presented earlier today, and the position that my party has taken with respect to the provision banning the sale of tobacco products.

If he were asked, he would say that Big V's decision is part of a 30-year plan that they have in place to reduce the sale of tobacco—they're down to 3% and heading to zero—in their premises. Their actual position is a total ban on retail sales and they want a tobacco control board introduced. That's my understanding of Big V's position, that it isn't some sort of curious thing that you can pit against Shoppers Drug Mart; it's a corporate decision they've taken as part of a long-term plan.

I don't see any great inconsistency in terms of they want a level playing field. They are not, it is my understanding, encouraging that the one part of the retail sector, that is, pharmacies, be discriminated against. They've made clear that they want cigarettes taken out of all retail sales and a tobacco board put in place. I say that as my understanding and give Garfield an opportunity to respond.

**Mr Mahood:** I know a wee bit about this. I met with Norm Puhl almost two years ago, a year and a half ago, and I said: "If you guys are wise, if you're concerned about traffic shifting to your major competitors, which are grocery stores, if you're really worried about that and you guys are good businessmen, you make a decision. You know it's going to come out of pharmacy. It's good corporate planning to figure out what are the odds that you guys are going to beat this and what are the odds that it's ultimately going to go through."

"If you take the decision that I recommend you take or make the assessment that I recommend you make, which is that sooner or later it's going to come out of pharmacy, then what you'll do, if you're smart, is you'll run a campaign to make sure it gets into controlled outlet stores, because then when the traffic shifts, nobody has a difference in traffic patterns, because it's gone into

controlled outlets."

The problem with that, of course, is that Norm Puhl has to work with David Bloom in the Ontario Chain Drug Store Association and there's no way that Shoppers Drug Mart's going to go along with this. So he got stuck. The fact is that it's not going to be that kind of unified recommendation for controlled outlets. Controlled outlets make the most sense. But that's not in the cards, probably, for this particular round.

I want to just finish off that comment by a couple of quick comments about Mr Bloom's presentation that relate to this. He said, "Patient counselling...is a key component of good pharmaceutical care." Let me tell you that there's going to be some research tabled here within the next week that will show that virtually nobody has ever been counselled. The overwhelming majority of smokers going into drugstores have never even had a peep uttered to them by pharmacists. That is just hogwash.

The second thing is that he made reference to the fact that the college was voted out. That also is just hogwash. The members of the college were not voted out the way the chain drugstores would like you to believe. In fact, this issue was revisited by the college in a major meeting last summer. They didn't alter its position. They stuck with their position. The impression that was left with you, which was that was an old college and the college doesn't have the same feelings now, is just hogwash. The fact is that the college is maintaining its position. I think that's responsible and they deserve credit because they're fighting Shoppers Drug Mart pharmacists right within their own board.

There's a lot of stuff that's going on in this whole pharmacy deal. I think over the course of the next two or three weeks you're going to see a major debate and the public will have a better understanding of why you have to get conflicting messages to kids out of the system and why you have to take it out of pharmacy.

**Mr Jim Wilson:** Thank you for your response, but let's be clear: The issue has been whether we should discriminate against one retail sector, namely pharmacy, and Big V's position is no, you shouldn't, that there should be nobody in the broader retail sector selling cigarettes.

Secondly, I think your advice to Big V two years ago was good marketing advice. Clearly, they know that this government was hellbent on bringing in this provision. It was clear to me, as Health critic some two and a half years ago, that this was the way it was going to head. We have a very difficult time changing this government's mind on issues like this. They are simply taking a better positioning in the market, and rightly so. They will be ahead of Shoppers Drug Mart in terms of the ability to fill their shelves with videos or something else when that product is removed. I think it was a wise business decision, but it in no way supports the position or the clause that's in this piece of legislation. Let me be clear on that.

With respect to patient counselling, the evidence that was given—other pharmacists asked the same question, including Shoppers Drug Mart pharmacists—was not that they automatically give counselling to everybody who



buys cigarettes; it was that when they were asked by a customer-patient, of course they would give counselling as professionals. I don't think anybody's denying that and I don't think anyone's taking that away from pharmacists. Let's be clear: When asked, they give the counselling.

1640

**Mr Mahood:** If I may answer that, although it wasn't a question, it certainly was an interesting—

**Mr Jim Wilson:** Factual statement.

**Mr Mahood:** It was factual, I guess, for the way the tobacco industry views factual. If I go into an auto parts retailing outfit, I don't go in and ask whether they sell underwear. If I go into a pharmacy and I walk through the front door and there's tobacco all over the place, I can't believe that people really believe they're going to get counselling when the pharmacist is selling the stuff at the front of the store. You don't ask for something that it seems logical you're not going to get in that facility. If a pharmacist is not selling tobacco and it's out of the store, someone might actually believe this is a health facility, which it is, and actually do something about it.

The problem with your legal product argument that the Conservative Party has taken is that the Conservative Party, on one hand, argues for the right of self-regulation of the professions, and then when the self-regulating profession comes before you and asks for legislation to deal with professional misconduct and ethical behaviour among the profession, all of a sudden you turn around and say, "No, you can't have it because we're not going to allow you to be self-regulating." There's a conflict there which I don't understand.

**Mr Jim Wilson:** There were many things during the RHPA that the colleges asked the government to do that the government didn't do. It's not an automatic that because a college asks for something, we as legislators say, "That's a great thing; let's just go do it," without any thought or public hearings. That's the only point I make.

**The Chair:** Thank you both for coming and for the material you presented. You are also going to submit a written brief to the committee.

Are committee members in a position to make a decision about the 23rd and the 24th tonight?

**Mr Jim Wilson:** Unfortunately, Mr Chairman, I'll have to get back to you tomorrow morning.

#### COMMIT TO A HEALTHIER BRANT

**Ms Dianne Ferster:** My name is Dianne Ferster. I am the executive director of Commit to a Healthier Brant, a demonstration site for the Ontario tobacco strategy. With me are Tara McIntyre and Leslie Falhazie, students from Brant county. I thank the committee for the opportunity to present today. This is our story from our community.

Allow me to set the stage with quotes from local teens involved in Commit teen support groups. This group met over the summer in response to teens in our community requesting assistance in quitting smoking. One teen states, "Smoking is tragically hip"; another, "I wanted to be sophisticated and one of the guys but I don't like it, I feel stupid and I'm addicted"; and a third, "If smoking is bad for you, why would pharmacies that look after our health sell cigarettes?"

Although Commit to a Healthier Brant registered for this presentation, the content and speakers reflect Brant county concerns and approaches to the issues outlined in Bill 119. The appendices include a full listing of organizations and individuals involved in this presentation.

At this time, we wish to commend the legislators and others who worked to bring forward this well-crafted piece of legislation. We particularly recognize the efforts of the Honourable Ruth Grier, Minister of Health, and those who preceded her for acknowledging the significance of this issue and for the development of the Ontario tobacco strategy. The efforts of individual members of the provincial Parliament, including members of the social development committee, are much appreciated.

We recognize that this legislation will continue to maintain Ontario and Canada as leaders in the fight to reduce the effects of tobacco-induced mortality and morbidity. We feel strongly that it is essential that this current impetus remain strong and that this piece of legislation quickly become law. However, there are some areas in Bill 119 that should be strengthened to protect the health of our children.

We wish to address three main areas of major concern in our community: environmental tobacco smoke, sales of tobacco products in pharmacies and access by minors.

Our first community representative is Tara McIntyre, who will explain how exposure to ETS greater affects her health and impacts upon her quality of life.

**Ms Tara McIntyre:** I am 12 years old and I have had asthma for all my life. Have you ever been walking in a mall or in a restaurant where someone is smoking near you? I have, and for me that can cause an asthma attack. A lot of people think an asthma attack is no big deal. Others don't even know what happens. Do you?

I'm here today to tell you that every asthmatic is different. When I take an attack caused by tobacco smoke, usually I smell the smoke. Then I get very weak and my head feels like it weighs 100 pounds. My nose and throat begin to burn. It feels as though someone is standing on my chest and someone else is trying to strangle me. My throat fills up with phlegm so it feels as though a balloon has busted in my throat and pieces of rubber are hanging and blocking my airways.

Tobacco smoke does not cause my asthma, but it is a major trigger for my attacks. When I take an attack, I have to take Ventolin. If I take much I have side-effects, like weakness and shaking. If I get really bad, I have to take more Pulmicort, which is a mild steroid. As it is, I have to take Pulmicort on a daily basis to constantly help control the inflammation, so if I am in an area where there is smoking I at least have a better chance.

If you do not decide to ban smoking from all public places, does this mean that you will pay for the costly medications asthmatics need to live a near-normal life?

I strongly advise you to ban smoking.

1650

**Ms Ferster:** The Brant county community partners support legislation that bans smoking in all public places. Only in this way will the health of our young people in Ontario be protected.



Now let's look at our second issue. The Brant community partners support the ban of sale and use of tobacco products in health care facilities. We strongly agree with the inclusion of pharmacies in this definition.

Over the past two weeks, Commit to a Healthier Brant conducted a survey of Brant county pharmacists to discover how they felt about the sale of tobacco products in pharmacies. One pharmacist from each of the 28 pharmacies in Brant county were interviewed to determine their reactions to Bill 119. We didn't call a specific pharmacist, just whoever was available at the time. Of the 28 pharmacies in Brant county, 16, or 57%, do not currently sell tobacco; 10, or 36%, do sell, and two, or 7%, were located in department stores that sell tobacco in other departments.

It should be noted that 90% of Brant county pharmacists felt that selling tobacco contradicts their professional code of ethics. Asked how they felt about the sale of tobacco in pharmacies, 70% of the pharmacists surveyed stated that they opposed the sale of tobacco in pharmacies, 10% indicated their support, while the remaining 20% of pharmacists were undecided on this issue.

At this time, I would like to restate that as Brant community partners, we support section 4 of Bill 119, which restricts pharmacies from selling tobacco products. It would appear, based on the information gathered from local pharmacists, that they would agree.

The final concern we will address today is access by minors to tobacco products. In 1990 and 1991, sting operations were conducted by Brantford Commit. It was a four-year research project in Brantford funded by the National Cancer Institute of Canada. Teams of youths aged 15 to 17 were able to purchase cigarettes easily and without question from retailers 74% of the time. After the first sting, we went back and we sent educational packages and spoke with retailers individually. When we decided to do a second go-round and see if this had made a difference in our community, it had not; 74% of retailers were still selling. Enforcement of the existing restrictive legislation obviously was not taking place.

This background information formed the basis of a campaign by the Council for a Tobacco-Free Brant to garner public support for more stringent enforcement policies. Adults and students demonstrated support for licensing of specific retailers to sell tobacco—an example given to us was the LCBO—and increased fines for retailers selling tobacco to people under 19 years of age. Some 67% of the youths surveyed—this was during National Non-Smoking Week this year—supported the restrictions, smokers and non-smokers alike.

Commit to a Healthier Brant and the Brant Haldimand/Norfolk Heart Health Project produced a National Non-Smoking Week radio campaign that encouraged Brant county residents to offer their opinion regarding Bill 119. We chose to get together to do that in the hope that our residents who were unable to be at the hearings could respond. We have brought their information; it is included in the document.

Results indicated that the majority of people supported a ban on sales of cigarettes from vending machines and in pharmacies. There was strong support for licensing of

vendors and restricting the purchase of tobacco products to those over the age of 19.

Smoking cessation and support groups have recently been available to teens in Brant county. The participants in these groups have helped confirm how easy it is to obtain cigarettes and how difficult it is to stop smoking.

Leslie Falhazie, a student at Paris District High School, has experienced this first hand and will tell you about it.

**Ms Leslie Falhazie:** I'm 15 years old and I would just like to tell you that the law has to be enforced on the sale of cigarettes. When you go into a store and ask for a pack of cigarettes and they give them to you without asking for any ID, that's a chance for you, as a young person, to get those cigarettes and you don't have to worry about giving them your ID, no matter what, because they're not asking for it. If they did, it would stop a lot of young people from smoking, because where could they get their cigarettes?

When you look at a pharmacy, you look at it as a place that's healthy. It's there to help you get better etc. When they're selling cigarettes, that's a major turnoff. It's not healthy at all. Smoking is not healthy.

Sometimes it's easy to buy cigarettes and sometimes it's not. For kids my age, there are some stores that do ask you for your ID, and there are some stores that don't. It really should be hard. You should have to give the store your ID to get cigarettes, no matter what.

I think that not selling cigarettes in a pharmacy is a very good idea, because it is a healthy environment and smoking is just not healthy and it's not easy to quit. That would stop a lot of people from starting.

**Ms Ferster:** In conclusion, our presentation has addressed the issues of environmental tobacco smoke, access to tobacco products by minors and tobacco sales in pharmacies from the perspective of Brant county residents. Our surveys and campaigns confirmed the willingness of our community to support strong measures to restrict access of minors to cigarettes and to ban the sale of tobacco products in pharmacies.

The Brant community also supports measures to secure smoke-free places, particularly public places.

The Brant County Community Partners in Action encourage strengthening the legislation to address our concerns. A strong enforcement component of this legislation will send a message that Ontario is serious about protecting the health of its youth.

You as legislators are setting the course of health for future generations. It is important that this legislation is strong and is enacted immediately. We ask you not to compromise health, particularly that of our youth.

On behalf of Tara, Leslie and the Brant county community, we would like to thank you and we'd be happy to respond to any of your questions.

**Mr Jim Wilson:** Leslie and Tara, when I was either of your ages, I don't think I'd have had the courage to appear before a bunch of parliamentarians in a public hearing, so you're to be commended for doing so.

What if we were to toughen this law even more? You said the current law, which doesn't allow retailers to sell

to anyone under the age of 18, doesn't seem to be working very well. Your experience is that in many cases it's quite easy to buy cigarettes, and I assume that's the experience of many of your friends.

What if we put the onus on you and said that people under the age of 18 shouldn't have cigarettes in their possession, shouldn't carry them and shouldn't be allowed to smoke? In other words, just like drinking, where the age limit's 19, make it illegal to smoke or be in the possession of cigarettes. Any thoughts on that?

**Ms Falhazie:** The law should definitely lay down a really heavy rule that no young people under the age of 19 should have cigarettes through a store or a pharmacy or any way, no matter what. I don't think fining a young person for having cigarettes is going to work. It's not going to work. If you fine them, that's like saying it to a person doing drugs, and really it is a drug but it's still legal. The only thing is that we shouldn't be able to buy them unless we're of age to buy them.

**Mr Jim Wilson:** The reason we float the idea is that the current system doesn't seem to be working too well and really this law doesn't change it much. It boosts it up one year to 19 and may have some provisions that are added after the law is passed with regard to the type of identification a store owner or clerk would have to ask for, and the fines. But some of us are thinking that the current system isn't really working too well and that maybe we should have a combination of making it illegal to smoke or to carry cigarettes under a certain age, and secondly, obviously you couldn't sell to those people either. Those were our thoughts.

1700

**Mrs Haslam:** I have the greatest respect for you young people. Mr Wilson's absolutely right. It's not easy to come before a committee, but you can go home tonight and watch yourself on TV so there is a bonus for you.

**The Chair:** As the Chair, I feel compelled to say you are all such a warm and fuzzy group, is it any wonder they came forward?

**Mrs Haslam:** This is true, but that's not true because, you see, Leslie's been here for a long time. I've noticed her and I commend you for your strength and your stamina to sit through this. We're here because we have some definite ideas.

I'd like to ask Dianne a couple of quick questions and then ask questions of the young people. You say that "90% of Brant county pharmacists felt that selling tobacco contradicts their professional code of ethics," but on the previous page that 35% still sell tobacco. I wondered if you'd questioned them about why they continued to sell. You did speak to the pharmacists. Did you ask them then, looking at the data, why they sold?

**Ms Ferster:** Yes. In most cases, it was a policy of the company and they were employed by that company. So it was not a decision that they as pharmacists had control over. This was a company decision.

**Mrs Haslam:** That's an interesting comment because somebody mentioned to me today that the problem with larger drugstores is that they are a retail organization that hires a pharmacist for the word "drug" on their supermarket

sign, and it's interesting that you mention the same kind of concept.

I am concerned that you say 74% went back to selling and that was a problem. Obviously, that indicates we are going to have to look at the enforcement side of whatever legislation we bring in. It boils down to an enforcement problem. Do you feel that the licensing aspect would be better in enforcement than what is being proposed in the legislation?

**Ms Ferster:** Yes, certainly we would support that, probably because it's already set up. It was something that came from the residents, adults in particular, but certainly the students addressed that and I think it's set up. When they think of licensing, they think of alcohol in the same way: They don't have access to alcohol. If we're thinking of the same age, 19, it would make sense that it would be under the same jurisdiction.

**Mrs Haslam:** What one thing could I say to you or to young people that you think would really turn them off the idea of smoking? We've heard statistics that 3,000 young people a week—

**Ms Murdock:** A month.

**Mrs Haslam:** Is it a month? I stand corrected, excuse me. It said 3,000 young people a month start smoking and it's a real concern to us, to all of us, to all parties. It's a real concern when we see 3,000 young people start to smoke when we've got education out there, when we have programs out there, when we try to eliminate the possibility and the accessibility of cigarettes. What one thing could we say to you if it's not, "You're going to die"? What one thing could we say to you, to your peers to stop them from going into this habit? I've put you on the spot and I'm sorry, but we really want to know.

**Ms Falhazie:** I don't think you can really say anything specific to one person because everybody's different and it's something they have to think about themselves.

**Mrs Haslam:** That's a really good answer.

**Mr McGuinty:** Thanks to all of you for coming and thanks for your little bit of information, Tara, on asthma. I have a little boy who uses Ventolin and he's got his own puffer, so I've become acquainted to some extent with some of the problems associated with asthma.

Leslie, I want to talk to you a bit more about this idea raised by Mr Wilson. I think kids are smarter; at least they seem smarter than I was at your age. They seem to know more about what's going on in the outside world, what makes things tick and I think they're prepared to assume more responsibility than we give them credit for. I think there may be an idea here. Kids understand that it's illegal to carry a mickey around at high school. Why couldn't we do the same kind of thing with cigarettes?

**Ms Falhazie:** Who's going to listen? Cigarettes or alcohol—cigarettes have long-term effects on you but it's definitely putting a lot—I don't know how to explain it.

**Mrs Haslam:** Say, "I don't know." We accept answers like that.

**Ms Falhazie:** Well, I don't know.

**Mr McGuinty:** The similarity, of course, is that alcohol is a legal product, but young people understand

that it's against the law to use it before they reach a certain age. I'm just wondering why we couldn't do the same thing with cigarettes, treat them in the same way.

**Ms Falhazie:** I don't think it would work.

**Mr McGuinty:** The kids would break the law?

**Ms Falhazie:** Yes.

**Ms Ferster:** If we're looking at what I've heard this afternoon about possibly charging young people, we're looking at something that is covered by the Tobacco Restraint Act of 1908. It now covers possession. You have to be 16 years of age to possess it. It's federal jurisdiction. It's not currently being enforced that I'm aware of. Should it be part of a comprehensive national strategy? Perhaps Ontario should provide leadership on this issue by pressuring the federal government to update and toughen that legislation. Possibly one of you could spearhead this. I would second the motion. It's a thought.

**The Chair:** I'm going to let Mr Eddy, who is from the wonderful county of Brant, pose the last question, thought, comment, wisp of wisdom.

**Mr Eddy:** That's a big role. Thank you for your presentation. I really appreciate your being here and thank you for your leadership in bringing healthier Brant citizens into being. We have a problem in that the underground economy is prevalent and growing in Brant and supplying contraband cigarettes. Are contraband cigarettes being peddled in schools? We've talked about legal outlets, but I'd like your comment on that.

**Ms Ferster:** Leslie, are you aware of cigarettes that are available that are not purchased at the stores that kids go to, Ohsweken?

**Mr Eddy:** Cheap cigarettes.

**Ms Falhazie:** It happens all the time at school. Every day somebody has a carton of cigarettes and is asking, "Do you want to buy a pack of cigarettes, \$5?" Of course people say, "Yes, I'll buy them from you, because if I buy from the store I'm going to have to pay \$6.50." It is happening all the time.

**Ms Ferster:** That's true. We see that in our county. I have grave concerns about what's happening in Ohsweken right now. Also this rollback federally would be a big mistake. If we rolled back taxes so that tobacco products were cheaper—how can you make this issue? We're talking lives and we're talking economics. We have 13,000 people dying. We have 1,000 farms producing tobacco in this province. That's more than 10 deaths per farm, if you look at it that way. That's pretty grave.

**Mr Eddy:** You are referring to a new cigarette manufacturer in Six Nations, Grand River territory.

**Ms Ferster:** Absolutely.

**Mr Eddy:** I'm really wondering about undercutting the price even further, if that isn't a possibility.

**Ms Ferster:** I also am concerned with that operation, with the standards there. We don't know what's in that tobacco. I don't know how it will be regulated. Tobacco could be worse, more than 4,000 carcinogens that we know of. It will likely happen there without regulations.

**The Chair:** Thank you all again for coming before the committee this afternoon. We very much appreciate your taking the time and particularly all the work that clearly went into your brief.

**Ms Ferster:** Thank you. It's been enlightening for us as well.

**The Chair:** Could I ask members to think about the date, so we can determine that tomorrow morning.

**Mrs Haslam:** It's my understanding that we want to add another day because you want to give everybody a chance. How many are on the list that we wouldn't be able to hear if we didn't come back another day?

**The Chair:** It was approximately a day of hearings.

**Mrs Haslam:** How many is what I asked.

**The Chair:** Whatever makes up a day. Was it 30, 28?

**Mrs Haslam:** Are we seeing 30 people a day now?

**The Chair:** Those are 15-minute presentations.

**Mrs Haslam:** No questions?

**The Chair:** It depends on the presentation. We've been trying to accommodate everybody. This committee in particular has really made an effort. We've been steadily together since the middle of October on two other major bills. We have always felt strongly that we would like to do that.

This is not adding another day to the committee's whole set of hearings, but there was agreement within the subcommittee that we wouldn't necessarily need four days on clause-by-clause, but three days, so let's take one of those days to try to accommodate more of the people who want to come before the committee. That's the reasoning and that was why the letter was sent to the House leaders, and they have agreed to that.

**Mrs Haslam:** I have a concern about the timing of it, but I'll talk about that with my caucus.

**The Chair:** Fine. Perhaps people could come with the 23rd or the 24th so we could fix that tomorrow. With that, the committee stands adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 1712.





## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

\***Chair / Président:** Beer, Charles (York-Mackenzie L)

\***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

\*McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Arnott, Ted (Wellington PC) for Mrs Cunningham

Haslam, Karen (Perth ND) for Ms Carter

Murdock, Sharon (Sudbury ND) for Mr Rizzo

Perruzza, Anthony (Downsview ND) for Mr Martin

Wessinger, Paul (Simcoe Centre ND) for Mr Hope

White, Drummond (Durham Centre ND) for Mr Owens

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service

Gardner, Dr Bob, assistant director, Legislative Research Service

## CONTENTS

Wednesday 2 February 1994

<b>Tobacco Control Act, 1993, Bill 119, <i>Mrs Grier</i> / <b>Loi de 1993 sur la réglementation de l'usage du tabac,</b></b> projet de loi 119, <i>M<sup>me</sup> Grier</i> .....	S-775
Ontario Lung Association .....	S-775
Mary Campbell, president-elect	
Dr Peter Webster, member, Ontario Thoracic Society	
Cathy Birks, representative, Ontario Respiratory Care Society	
Committee of Independent Pharmacists .....	S-780
Larry Rosen, past president	
William Rutsey, Coopers and Lybrand	
Eric Leonard, Coopers and Lybrand	
Dr Atif Kubursi, McMaster University	
Bernie Ceifets, member	
Retail Council of Canada .....	S-785
Alasdair McKichan, president	
Peter Woolford, vice-president	
Ontario Chain Drug Association .....	S-789
Sherry Porter, executive director	
Steve Mezei, vice-president, operations, Pharma Plus	
Shoppers Drug Mart Ltd .....	S-792
David Bloom, chairman and chief executive officer	
Marj MacKenzie, pharmacist-owner, Shoppers Drug Mart stores	
Heart and Stroke Foundation of Ontario .....	S-797
Rosemary Leach, manager, professional education	
Dr Anthony Graham, board member	
Respiratory Therapy Society of Ontario .....	S-800
Yvette Dumont, president	
Susan Marshall, respiratory therapist	
Shawn Kenny, president-elect	
Canadian Automatic Merchandising Association .....	S-803
David Orriss, president	
Paul Runstedler, acting treasurer	
Cynthia Davenport, manager	
Non-Smokers' Rights Association .....	S-808
Garfield Mahood, executive director	
David Sweanor, senior legal counsel	
Commit to a Healthier Brant .....	S-814
Dianne Ferster, executive director	
Tara McIntyre, member	
Leslie Falhazie, member	



CAZON  
XC 7  
-577

S-32



S-32

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Thursday 3 February 1994

## Standing committee on social development

Tobacco Control Act, 1993

Chair: Charles Beer  
Clerk: Doug Arnott



# Journal des débats (Hansard)

Jeudi 3 février 1994

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Président : Charles Beer  
Greffier : Doug Arnott



### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 3 February 1994

The committee met at 1007 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Welcome to our fourth day of hearings of the social development committee on Bill 119.

Just before calling our first witness, I would like to get direction from the committee. As you recall, the House leaders have given us permission to use one of the clause-by-clause days for public hearings so that we will, in fact, be able to hear from everyone who has asked to present. The two days that were to be considered were February 23 and February 24.

Is February 24 acceptable to everyone?

**Mr Dalton McGuinty (Ottawa South):** Yes, it is.

**Mr Jim Wilson (Simcoe West):** Yes, it is.

**The Chair:** Okay. For the clerk's benefit then, we sit on February 24, and we'll let you know a little later in terms of numbers and the hour of sittings.

The second issue was for clause-by-clause, which is the week of March 7. What I would propose is beginning Monday, March 7 at 1 o'clock and then having the Tuesday and Wednesday as the other two days that would be there if needed. Is that acceptable to all parties?

**Mr McGuinty:** That sounds most acceptable.

**Mr Jim Wilson:** Agreed.

CITY OF TORONTO  
DEPARTMENT OF PUBLIC HEALTH

**The Chair:** With that out of the way, I'll then call on the representative from the city of Toronto, department of public health. If he would be good enough to come forward, and please identify yourself for Hansard. We have a copy of your submission. It's healthy Toronto water.

**Mr Jim Wilson:** Should have been York region.

**The Chair:** Yes, via Lake Simcoe.

**Dr Perry Kendall:** Actually, it's not true that Toronto drinks its own bath water; it only thinks it does.

My name is Perry Kendall. I'm the medical officer of health for the city of Toronto, department of public health. Good morning and thank you for the opportunity to be here to present today.

I'd like to congratulate the government for bringing the bill forward and the opposition parties for supporting it.

The health community has been fighting for this kind of legislation for a long time, and the department of public health in Toronto is a member of the Ontario

Campaign for Action on Tobacco with all major Ontario health organizations.

As a member of that organization, we support the recommendations in the brief presented to you earlier this week. My remarks today are intended to support those recommendations and to elaborate on our most important concerns.

I'd like to start by saying that the real beneficiaries of this legislation will be the children: the children who don't start smoking because of it; the children who won't grow up to develop heart disease or cancer because this government, supported by the opposition, had the political will to pass this piece of legislation. Tobacco does exactly what the Ministry of Health's powerful new anti-smoking commercials say it does: It sucks the life right out of you. It is the number one health issue in Canada.

Dr Richard Schabas, the province's chief medical officer of health, has said that tobacco kills more than 13,000 Ontarians every year, 6,000 of them from ischemic heart disease. It contributes to many cancers. It causes lung cancer, strokes, emphysema, chronic bronchitis and low birth weight in children of mothers who smoke.

The Environmental Protection Agency in the United States has classified environmental tobacco smoke as a group A carcinogen, and there are only 15 other substances in this category, which include radon, benzene and asbestos, a substance we believe so dangerous when it's in the atmosphere that we remove it from our homes and offices.

Yet one of the major problems we have getting kids not to start using cigarettes is their easy availability. Another reason is the obvious gap between the reality of what tobacco does to our bodies and the massive promotion of it by the industry. The tobacco industry has funnelled millions of dollars into promoting this toxic product. Manufacturers have dressed cigarettes up in fancy wrapping, they've promoted them to vulnerable and impressionable youth and they've said there is still no hard evidence that tobacco kills. George Orwell couldn't have done a better job at doublespeak.

The industry would have you believe it isn't targeting youth and women, and that those thinly disguised cigarette ads promoting the Matinee Ltd Fashion Foundation have nothing to do with tobacco. If you watched the reporters from CTV or CBC when they went out in the TTC and they asked teenage girls what the adverts were promoting, it was very clear. They just said: "Tobacco, of course. Cigarettes."

When you're debating this bill, when you're considering the amendments suggested by the Ontario Campaign for Action on Tobacco, I'd ask you to weed out the doublespeak and look at the reality of what is happening, because the reality is that the health care system cannot afford for you not to pass this bill. Bill 119 is essential



for health reasons, it's essential for ethical reasons and it's essential for economic reasons.

When Toronto studied the economic impact of smoking in 1991, we found that it cost the city \$193 million a year in costs related to direct health care and income losses due to absenteeism and premature death. That study didn't even look at the costs related to harm caused by secondhand smoke, which include the increased risk of leukaemia, asthma and respiratory problems, including sudden infant death syndrome, in the children of smokers.

The study found that a 30% reduction in the number of people who start smoking would lead to a 30% reduction in deaths caused by smoking. A 50% reduction in smoking would lead to a commensurate 50% reduction in deaths.

The key to reducing health costs related to smoking is to stop kids from ever starting, because studies clearly show that if you haven't started smoking by age 19 you're not likely to, and some 3,000 Ontario children start smoking every month. This is an important reason for raising the age of purchase to 19 and for requiring photo identification for buyers and licensing for sellers. We support these provisions in the bill.

The tobacco industry has used some powerful and successful techniques to seduce new smokers to replace those who quit or die, and the health effects are showing. I'll give you one example: Thirty years ago, lung cancer was virtually unknown in women. Last year, more than 5,000 women in Canada died of it. This represents a five-fold increase since the Second World War, when women took up smoking in large numbers. Soon, more women will die of lung cancer than of breast cancer, and there is some indication that already the lines have crossed.

If we look at the women's health lobby for more funding and research into breast cancer, and if we try and imagine there was a product on the market that caused breast cancer with the same certainty that cigarettes cause lung cancer, I just cannot imagine that, given the strength of that lobby, that product would be on the shelves in six weeks from the time the lobby started; a sad epitaph for all those women who breathed in the contents of those elegantly packaged Virginia Slims with the tag line that, "You've come a long way, baby."

Teenage girls in Canada now smoke more than teenage boys; 20% compared to 12%, according to Health Canada's 1991 general social survey. If we don't take strong action to stop this epidemic it will be too late. These youth and thousands like them who turn to cigarettes to deal with such problems as stress, body image and poor self-esteem will be gasping their way to the grave. They'll get hooked, and they're really hooked. The Addiction Research Foundation says that nicotine is as addictive as heroin, and it's borne out in this by the US Surgeon General's report of 1989.

But if we tell kids not to start, not to open the door to addiction and poor health, we have to back our words up with real action. If we say that smoking kills, we have to show that we believe it. We cannot persist in double messages and double standards. We have to show that we mean what we say. We have to do something to stop the malaise and disillusionment our youth have with the

leaders in our society, leaders who sometimes appear to say one thing and do a completely other thing.

The provisions in Bill 119 for plain packaging, provincial health warnings, improved control over cigarette sales and the banning of vending machines are important ways to reduce attractiveness and access to youth. They're also an important statement on health.

One of the most disheartening double messages in the tobacco business is the percentage of sales in pharmacies. Twenty-three percent of all tobacco sold in Canada is sold in pharmacies. What message does a teen get, what message does an adolescent get, what message does anyone get when a health outlet sells cigarettes?

Shoppers Drug Mart, owned by the same people who own Imperial Tobacco, want to keep profits up by selling a product that kills. Such sales show a blatant disregard of the most fundamental health issue of our time. You cannot be a health professional and sell cigarettes. The two activities are ethically incompatible, especially when you're in the position of then selling the remedies to palliate the harm done by the cigarettes you sold in the first place. Canada and the United States are the only nations in the industrial world where pharmacies also sell tobacco.

The pharmacists' professional regulatory body, the Ontario College of Pharmacists, supports this bill and asks for a prohibition on sale in pharmacies. I urge the government to reject the arguments of the tobacco lobby and to send a strong message to our youth that their health is more important than the powerful tobacco lobby. I ask you to bring the ban of sales in pharmacies into force within 90 days of royal assent, and to clarify the definition of "pharmacy" to ensure that tobacco products cannot be sold in any contiguous retail space.

I'd like to comment briefly on the issue of environmental or secondhand smoke. It wasn't too long ago that public hearings on important health issues such as this would have posed a threat to the health of everybody in the room. People with chronic illnesses such as asthma and heart disease would have had to sit through a haze of smoke in order to attend meetings on important social issues. We've come a long way in protecting people from secondhand smoke, but we still have a long way to go.

Section 9 of this bill will increase public protection, but it needs to be expanded to include all public places, such as recreation centres, shopping malls, theatres, restaurants and fast-food outlets. Bylaws controlling secondhand smoke are springing up all over the province, with various degrees of restriction. It's becoming confusing to the public and, in some ways, I think, unfair to merchants and restaurateurs, and poor health policy. Cancer and lung disease will not adhere to municipal borders. An amendment proscribing smoking in all public places except where specifically permitted, the reverse onus position, would provide increased protection from a known and severe health hazard.

The city of Toronto has been a leader in trying to eliminate secondhand smoke in workplaces and public areas, but municipalities cannot do it alone. In responding to individual municipal strictures, the Ontario Restaurant Association calls for a level playing field. I submit that

the provincial government could provide that. In fact, I submit that the province must bring uniformity to this issue.

Smoking in the workplace is another issue which is not addressed in this bill, and it is a major omission. The workplace restrictions under the present provincial act are really grossly inadequate. To be effective, the act needs significant amendments that would enshrine the right to a smoke-free workplace. It would be an important statement if the government moved quickly to support this bill by also amending the Smoking in the Workplace Act.

The brief you have from the Ontario Campaign for Action on Tobacco deals with problems around the issue of packaging, health warnings and signs, as well as issues around point-of-purchase tobacco displays, tobacco paraphernalia, kiddie packs, spitting tobacco and licensing.

I won't take any more of your time to address these issues, except to ask you to bring in a clear ban on chewing or spitting tobacco. This product can lead to cancers of the lip and oral cavity and pharynx as well as to non-cancerous oral conditions, nicotine addiction and dependence. Spitting tobacco is being used by baseball players, who are important role models for our children, and has the potential to become a major health problem. You have the opportunity now to put a halt to its spread in Canada, the opportunity to further protect our children.

1020

In closing, I will ask you to reject the arguments of the tobacco lobby, and I will ask you to support health, to strengthen this bill and give it a speedy passage.

Enviro-nics polls show clear, majority support from smokers and non-smokers alike for further control of access to tobacco. The only significant opposition comes from the tobacco industry or its agents. You cannot let that industry lobby delay or water down this critical bill. To do so would be to abdicate responsibility and to count the cost in preventable deaths, disease and disability. I thank you for your time.

**The Chair:** Thank you very much, Dr Kendall. We'll move to questions, beginning with Mr Wilson.

**Mr Jim Wilson:** Thank you, Dr Kendall. Towards the end of your brief, you make a very good point about the fact that smoking in the workplace is not addressed in this act. I must admit, because it isn't addressed in the act, it's been a while since I've looked at that piece of legislation. I was wondering if you had comments on the current Smoking in the Workplace Act. I also would ask either the parliamentary assistant or legal counsel to give us some highlights of that act, and perhaps the parliamentary assistant could explain any discussions they had as to why workplace legislation isn't included in the Tobacco Control Act. Any order.

**The Chair:** If you want to make some comments, Dr Kendall, and then I'll ask the parliamentary assistant to comment.

**Dr Kendall:** The only way of protecting non-smokers in a workplace is essentially to have a smoke-free workplace. One could permit smoking in an area which is physically enclosed, separated and ventilated to the outside to accommodate smokers.

The current provincial workplace act doesn't do that. Essentially, my desk could be a smoking area, and your desk would be a non-smoking area. The fact that tobacco smoke obeys the laws of physics and not the policies of the workplace has been pointed out in the past. It's a little bit like saying, "Your part of the swimming pool isn't chlorinated, but my part is." It just doesn't work for that reason.

**Mr Jim Wilson:** Just facetiously, today we have chlorine in the pool; yesterday Mr McGuinty had something else in the swimming pool.

**Dr Kendall:** Yes.

**Mr Jim Wilson:** That's essentially all that act does, if I could ask the parliamentary assistant?

**Mr Larry O'Connor (Durham-York):** The Smoking in the Workplace Act, which came out I believe in 1989, designated 25% of the workplace as a smoking area. The way that was to be established was a joint committee between representatives of the employers and the employees. At that time it was a significant piece of legislation. There certainly is a strong argument for moving forward with something else. That has to be dealt with by the Ministry of Labour.

In our discussions a year ago in trying to work through the tobacco strategy, it was felt that we move forward as quickly as we can with the Tobacco Control Act, to regulate the provisions of sales to young people. The key here right now is "to young people," and if we can focus our attention on that, the other element, yes, does need to be dealt with at some time.

I don't think that anybody would come to the committee and advocate for what we're doing now to be slowed down so that we can broaden the debate to include workplace avenues. It does need to be talked about, but it would definitely slow this process today if we were to try to include that in it.

**Mr Jim Wilson:** Really, this is just for information. Do you know whether your ministry or the Ministry of Labour has done any follow-up with respect to compliance or effectiveness of the 1989 workplace act? I'd be interested really just in any papers on it, because it comes up in a number of the presentations and I just can't get my mind on it.

**Mr O'Connor:** At this point I can't. I cannot offer you any, other than that I know the Ministry of Labour responds to complaints by employees, which is how it's dealt with today.

**The Chair:** Perhaps we could just make a request that if there is any information, any kind of a report or anything, there may be something there that would be useful. I think that would be an interesting thing to know.

**Mr Jim Wilson:** Yes, I'd be interested to read it.

**Mr McGuinty:** Doctor, thank you for your presentation. You have mentioned something in here which a number of other presenters have as well, and that is this business of a reverse onus provision that comes to smoking in a public place. It's something that I've been trying to get hold of and I think that holds a certain amount of appeal. But what criteria would you have to meet in order to qualify for an exemption? I'll give you



a couple of examples: Legion halls and bingo halls.

**Dr Kendall:** I think Legion halls would make a case for qualifying under the exemption on the grounds that a number of their members smoked, were unlikely to quit smoking, but the grounds for the exemption would be that they would have to provide a separately ventilated, physically enclosed space so that non-smokers were not exposed to environmental tobacco smoke. I think you can make the same case for bingo halls, that you first would have to apply and then you would have to be prepared to make a separately enclosed space. The law essentially will protect non-smokers from smokers, so the commitment would be that your smokers have a place where they can smoke but it has to be physically separated and ventilated to the outside and preferably under negative pressure.

**Mr O'Connor:** Knowing that Toronto has very active bylaws, I just wondered if you could offer us any advice. We've heard people coming before the committee suggesting that we go with a licensing scheme and I think that we've got enforcement mechanisms in the legislation that would be very effective without going to a licensing scheme. I wondered if you could comment on the enforcement mechanisms that Toronto uses and if you have any suggestions of how we could model something after some of that enforcement.

**Dr Kendall:** Basically, on enforcement I'm supportive of the position of the Ontario coalition, which is that they will support the provisions of this bill pending an evaluation, but their feeling is that in the long run it would be wise to move to a licensing system with licences for the sale of tobacco.

In the city of Toronto we have a double way of assessing the bylaws. One is by swift response to complaints by environmental health officers and the other is that our environmental health officers have, as part of their job, enforcement of the bylaws during their regular inspection visits to restaurants or health care facilities. A couple of years ago we added a provision that they would also look at the adherence to the bylaws around vending machines, which were supposed to be within eyesight and control of an operator of a facility.

We're lucky perhaps in that we have more resources than others and have been able to do that in the past. I think to move it routinely onward, most health units, including ours now with the economic downturn and the staff restrictions that we face, would require assistance in adding environmental health officers to adequately enforce and monitor compliance with our bylaws.

We have found that compliance is acceptably high. A minority of workplaces and a minority of restaurants aren't in compliance. Once we find they're not in compliance they rapidly come into compliance. We've been very pleased with the way this has worked, but if we hadn't followed it up I don't think we'd have had that degree of compliance. People would have realized that they could get away with it.

**Mrs Karen Haslam (Perth):** I wanted to talk compliance also, but that does beg the question then, since you're talking about the money available for health officers or for bylaw enforcement officers in that in some

cases that isn't working as effectively, do you feel a licensing setup would be better positioned for enforcement than the statute model that we're putting forward at this particular time in this particular piece of legislation?

**Dr Kendall:** Rather than hold up this present bill I would suggest that you monitor compliance and enforcement and be prepared to put in place a self-financing licensing system if it were shown that compliance and monitoring were inadequate.

**Mrs Haslam:** When you say "monitor," there was a suggestion that there be a report on the effectiveness and whether it was working. Is that what you're recommending, similar to what we've heard before as a year-end report to the Ministry of Health, something along that line?

**Dr Kendall:** Yes, and I think you would include in it that we did surveys. We monitored by doing a survey, visiting a randomly selected number of institutions where the bylaw was in effect and observing directly and asking questions. That was how we did some monitoring, and I would suggest that that be built in after the passage of this bylaw.

**Mrs Haslam:** Did you find that the compliance helped curb young people from access to tobacco products?

**Dr Kendall:** I think that there are so many countervailing forces going on at the same time that statistically what we see in young people is a kind of flattening, if you like, and some indication that younger women are taking up smoking preferentially. I don't have a really up-to-date survey of young people in Toronto, so I'm just looking at Ontario statistics and assuming that Ontario would be the same.

**The Chair:** Thank you very much, Dr Kendall, for coming before the committee this morning.

1030

#### MEDICAL OFFICERS OF HEALTH OF THE GREATER TORONTO AREA

**The Chair:** If I could then call on the medical officers of health for the greater Toronto area.

**Dr Jim Mitchell:** I'm Jim Mitchell. I'm the medical officer of health for the city of York but I'm representing all six medical officers of health of the Metro Toronto area. Even though some of us are going to make separate presentations—for example, you've had a presentation from Dr Kendall already—we have also agreed to make a joint presentation.

**The Chair:** Would you mind just introducing your colleague who has also come to the table.

**Dr Mitchell:** This is Dr Egbert, who is the medical officer of health for the city of Etobicoke.

I'd certainly like to begin by congratulating you on taking steps to restrict the leading preventable cause of death and disability in Ontario. It kills 13,000 Ontario residents every year. The setup of my comments will follow the format of the bill.

With regard to section 3 about the provision of tobacco to persons under 19, I'd make the point which Dr Kendall has already made, that most of the people who smoke



began smoking before they were 19. If they reach the age of 20 without smoking it's very unlikely that they will ever become smokers during their life. In enforcing this, using age-of-majority cards and photographic identification would be very helpful. I might even suggest that sales be further restricted by either licensing all the tobacco retailers, and this can be a self-financing sort of licensing through licensing fees, or you may even wish to consider restricting tobacco sales to a few stores such as the LCBO stores.

With regard to section 4 about prohibition of sales in designated places, the one that seems to be taking most of the press headlines is with regard to pharmacies. I would point out, as I presume the pharmacy association is going to point out, that the professional body of the pharmacists has requested this legislation. The opposition comes not from the pharmacists but rather from the owners of the pharmacies, the owners of the pharmacies who are themselves owned by a corporation that also owns the largest tobacco company in Canada, which I believe has a very distinct conflict of interest. The pharmacists themselves, who do not have a conflict of interest, are quite definite in not wanting to sell tobacco.

With regard to the argument that's been brought forward about loss of income, in 1992 the Canadian Pharmaceutical Association did a survey of 56 pharmacies and it found that the great majority of them had no income loss or a minimal income loss, 13 stores had marginal losses and 7 had moderate losses, but within two years these losses had been recouped.

With regard to sections 5 and 6, packaging, health warnings and signs, I'd like to make two points. One is kiddie packs, that is packs which have fewer than 20 cigarettes in them: We believe that these are put together for one purpose only and that is to make them cheaper so that children can afford to buy them. That is in clear violation of the law, which says that you should not sell to children.

With regard to plain packaging, a recent survey by the Canadian Cancer Society concluded that young people, who are the ones who are being recruited into this habit which is going to kill some of them, are much less likely to start smoking if cigarettes are not packaged in these nice, attractive packages which are designed by cigarette companies to sell cigarettes.

Section 7, about vending machines: We can simply say that we applaud your decision because this is a major loophole; that is, vending machines are a major loophole in letting cigarettes end up in the hands of children, because vending machines simply are not well supervised.

With regard to reports in section 8—I mention it here simply because it refers to reports; it's not reports from wholesalers and distributors—we do think it would be very helpful to require a report annually from the chief medical officer of health of Ontario informing the Legislature of progress towards the province's tobacco use reduction targets and the effectiveness of this act which you're debating right now. We think this would be very useful, something like the Auditor General's report, in bringing to the public eye the state of tobacco in the province every year.

About sections 9 and 11, about controls related to smoking tobacco, I would again mention, as Dr Kendall did, that there's one big omission here, and that is the workplace. I am not an expert in the legislative process and it may be that it's better to put this into a separate act rather than amend this act, but I would point out that there is a very gaping omission in this with regard to restricting smoking, and that is the workplace where the majority of adults spend the majority of their waking hours, and this should be covered.

It's very short, and I think I'll let you catch up on your timetable. We felt it would be more appropriate to be to the point rather than to take a long time.

**The Chair:** Thank you, and that gives us more time for questions, too. We'll start with Mr McGuinty.

**Mr McGuinty:** Thank you both for your presentation. We have a couple of products in the province here which are legal and we treat them similarly to some extent. We've got cigarettes, tobacco products, and then we have alcohol. Cigarettes, it seems to me, are much more addictive than alcohol, although alcohol if abused can become addictive. They both can cause illness, but cigarettes even more so in terms of even a little use can hurt.

Cigarettes present us the number one preventable illness in the country, but what we've done is we've told kids that it's unlawful for them to use alcohol below a certain age; in fact, we've got a law on the books that says it's an offence for them to consume alcohol before they're 19 years of age. Why don't we do the same with cigarettes? Why are we short-selling kids in terms of their ability to assume responsibility?

**Dr Mitchell:** I'm not quite sure the point you're getting at, but one of the things that concerns me about what I think you're arguing about is the relationship between what really should be done and what the law says, and the law frequently does not reflect reality or what should be happening. Whether something is legal or illegal is as much due to a societal quirk as anything else. For example, if tobacco were to be introduced today as a new product, it would not be allowed because it's known to cause death and disability. It is present in our society because it came in at a time when society didn't know the harm that was going to result from that. With some other things, like heroin and cocaine, we do know that and as a result they're illegal.

**Mr McGuinty:** Why should an 18-year-old, for instance, not be assigned some responsibility for smoking when we recognize as a society that it causes all kinds of problems, health and economic? Why are we letting them off the hook, so to speak? Wouldn't a more comprehensive approach—I'm just floating this—to dealing with the problem require that it's kind of a two-way street? If you sell it, it's a problem; if you buy it, it's a problem.

**Dr Mitchell:** This legislation that we're suggesting is just one part of a lot of things that are being done with tobacco. The thing that you do not see here is the education which is going on in the schools and elsewhere directed at children, pointing out to them that tobacco is not something that they should have anything to do with.

The other thing is—I don't know whether you're intending it this way—but I detect a strong flavour of blame-the-victim in your question. The reason I react to that is that people have an ability to resist up to a certain point. If there is one person who is doing something and everybody else in the society is doing something different and getting on that one person for not doing it, then that person is very likely to go along with it. Call it peer pressure with regard to smoking; call it advertising which encourages people to smoke, which is still present in the United States and spills over into this country whether we like it or not.

1040

There is certainly an element of individual responsibility, but I would in no way put the entire onus on the individual, because one individual is just that, one person, and if you try to stand them up against the tide of the entire society, they're not going to be able to stand up against that.

**Mr Jim Wilson:** Thank you for your comments. Mr McGuinty is floating an idea, or in fact stealing an idea, that was put forward by my party yesterday. But none the less, I think we both share a concern and I think agree that we've seen enough evidence in the few short days that we've been sitting in this committee to at least have the idea in our heads that the current model doesn't seem to be working very well, that some new teeth have to be put into the system to really drive the message home.

I guess what I didn't hear in your response, although I did appreciate the fact that perhaps—and I didn't think of it before, when you talk about we're sort of putting blame on the victim, and I'll think about that. But what I didn't hear in your response is why we treat alcohol so much different than cigarettes and why, in the current model, the people who are responsible and the people who are punished are the retailers. All we're doing in this bill is bumping it up one more year, to 19 years of age, than the current law.

I'd like to know from you whether you think it's feasible, why don't we make either the possession or the consumption of cigarettes for those below the age of 19 or below the age of 18 illegal, like we do for alcohol? We would probably need a phase-in period because a number of young people are addicted now, but have the medical officers of health, or anyone, explored this in any great degree?

**Dr Mitchell:** I think the prime reason is that it tends to go along, we feel, the blame-the-victim philosophy. We feel it's better to go after those who are selling and profiting from the sale of these products rather than the persons who are being victimized by them. There's profit in this, lots and lots of profit. I don't need to tell you that, but there is.

**Mr Jim Wilson:** There's profit in pornography which leads people to do awful things when they're addicted to pornography, yet in that case we punish both the offender and the people who propagate pornography. There are thousands of substances and things in this world that are bad for you that the law treats both sides of the equation punitively. And we don't do that, we don't put any responsibility on the young people who are clearly

seeking out illegal cigarettes. I don't think you totally get bribed to buy a carton of cigarettes. I think it's a two-way street. You've got to have the money in your pocket to buy them, and you're making a decision that "I'm going to go buy cigarettes," in lieu of buying a football, or something else.

So, I think there should be some responsibility on young people. What do you think of that?

**Mrs Haslam:** Letters, we'll get letters.

**Mr Jim Wilson:** We're going to get a lot of letters and phone calls, but it's fun.

**Dr Mitchell:** I don't know the individual members here or their party affiliation and, quite frankly, I don't know whether this is an honest suggestion or a method of trying to derail this legislation.

**Mr Jim Wilson:** That's an unfair—

**Dr Mitchell:** Since I really don't know your motivation, I find it difficult to respond to you more than what I have done already. I think this act is an excellent start. It is not perfect, but just as the longest journey starts with one step, I think this is one more step in the journey and I think we ought to take it. If it's not complete, then fine, you can come back and improve it, as you suggest.

**Mr Jim Wilson:** Just to alleviate your concerns, questioning our motives—

**Mr Anthony Perruzza (Downsview):** You've got only one motive.

**Mr Jim Wilson:** —is not really the best idea and I take offence to it. It is a sincere effort. I mean, we take heat when we float these ideas. People don't like them. I think, just for the record, so you'll understand, all three parties agree with about 98% of the contents of this legislation and the hearings have simply boiled down to a couple of contentious issues. Given the fact that the government's decided we're going to have four weeks of hearings on tobacco, we're floating around some other ideas which may lead to future legislation.

**Dr Mitchell:** May I also suggest that the other two medical officers of health may have some ideas about this. I believe Dr Egbert and Dr Kendall would also have some comments as well.

**Dr A.M. Egbert:** Let me add in response to the question that it would be ideal, a step in the right direction, to have the same regulation for the sale of cigarettes as it is for alcohol and raising the age in the same manner to the level of 19, as it is for alcohol. I would think it would be even better to have photo identification of persons purchasing cigarettes and regulate it in that way. It would be more effective. Similarly, the licensing of sellers, the availability of cigarettes from agents who are licensed to sell cigarettes, and perhaps even going a step further of having cigarettes only being sold in certain premises, such as LCBOs or Brewers Retail, would also be a step in making access more difficult.

**The Chair:** Did you wish to comment on that? Please, welcome back to the table.

**Dr Kendall:** Thank you. On the issue of whether one should have sanctions against underage persons who smoke or possess cigarettes, I think you'd really want to



examine that looking at the numbers of children who currently possess and smoke cigarettes, which we're trying to discourage, because if you were to pass such a bill tomorrow or next month, you would at a stroke put 50% of our children at some time or another between the ages of 8 and 19 on the wrong side of the law. I think there will be social and economic and philosophical issues there which would need some more debate and discussion than we could probably give them this morning.

**Mr Jim Wilson:** Just a final comment. I appreciate that and thought of that to the extent that perhaps you would pass a law saying effective several years from now—because this law speaks to a target of 1995, smoke-free places. So it's not impossible in law to grandfather, as it were, or set a target, or simply do it as part of the tobacco strategy and say that by the year 2010 or whatever, we will make it illegal along these lines.

**Mr Noel Duignan (Halton North):** I am one who has never smoked—never have; never even wanted to—and I believe the companies that actually manufacture cigarettes are in fact manufacturers of death and people who sell it are dealers in death as well. That's my own personal opinion, and if that's the case, like alcohol, we should tightly regulate and control the sale of tobacco products.

I was wondering about your opinion. At the federal level should we be placing cigarettes under the Hazardous Products Act? By doing that, then we can tightly control the importation, the advertising and the selling of the cigarettes. Would you encourage actually the federal government to look at moving the whole question of cigarettes under the Hazardous Products Act?

**Dr Mitchell:** Dr Kendall says that he's done a bit of research on that and I'll let him comment.

**Dr Kendall:** I was going to cede the floor to Dr Egbert, who wanted to go first.

**Dr Egbert:** I certainly agree that the federal government should be moving in that direction. I understand in the States cigarettes have been classified as one of the hazardous products, and perhaps our federal government should be moving in that direction. I would certainly support that.

1050

**Mr Duignan:** I believe some of the problems experienced in relation to the smuggling of tobacco across the border could be more effectively dealt with under this act than under the present situation they're experiencing right now.

Also, maybe you could tell me a little bit about how in the municipal workplace you regulate smoking or what you're intending to do or how you're going about doing it right now.

**Dr Egbert:** Etobicoke has been known for many, many years to be a leader in regulating the sale of cigarettes and cigarette smoking in our community. We have very stringent local bylaws to regulate smoking. Our bylaws regulate smoking in bus shelters, bingo halls, bars and even private workplaces. I think the legislation, Bill 119, should move in that direction, to regulating smoking in private workplaces. I would certainly like to see some

amendments to make the regulation even more stringent, as it is in some local municipalities.

**Mrs Haslam:** I'd like to build on that, because that was an area I wanted to ask you about too. Bill 119 allows for more restrictive legislation at the local level through municipal bylaws, and some municipalities have or have requested private legislation to enable workplace smoking control restrictions in public places. What would municipalities like to see included in Bill 119 to help address some of these concerns? Would they like to see more restrictions in this legislation, or would they like to see more availability for local municipalities to put in place the legislation that is necessary?

**Dr Egbert:** I think it would be much more appropriate to have a provincial act to regulate smoking throughout the province of Ontario rather than each municipality seeking private legislation, as we have done in Etobicoke, to come forward with more stringent local bylaws. I think it should be uniformly applied throughout the province of Ontario.

**Mrs Haslam:** One more quick question. This is a great report, let me tell you. I keep all the reports. This is the most comprehensive, short, not-more-than-50-pages report I've ever seen. I really like this, because you were succinct, to the point and I've got little checkmarks saying: "Gee, this is great. It really lays it out for me." So four pages; I'm impressed with this, rather than the 54 that go on and on. Not to say that other reports aren't good; it's just that this really draws together exactly where you want to be and exactly what you want to say.

I want to go into the time lines question. You talked about tobacco control. You looked at vending machines, and I've got "time lines" written there because they're in a situation. We've had them come to us and say, "We really need some time to get the vending machines under control and out of the areas," and the time lines around a tobacco control board.

Do you feel the timing is right? Should this legislation put in place a tobacco control operation, or do you feel this is a good step and perhaps we should see this as a step going forward and the long-term goal would be similar to an LCBO? I just don't know if socially in our culture and in our society the timing is right for a tobacco control board.

**Dr Mitchell:** You're probably correct. I put in that concept about selling it only through the LCBO simply because I think ultimately that's a very good way to go. I would not at all disagree that it might be a little bit early for the province of Ontario. We're probably not ready for it.

**Mrs Haslam:** That's all the questions.

**The Chair:** Did anyone else want to comment on that, just before we close?

Thank you, gentlemen, for coming before the committee and for the presentation you've made this morning.

ROYAL CANADIAN LEGION

**The Chair:** I call the next witness, from the Royal Canadian Legion. As he is coming forward, I'd just note for members of the committee that we've circulated a copy of the Smoking in the Workplace Act and also the



news clippings from the last day or so.

**Mr Jack Currie:** I'm Jack Currie, veterans' service officer for the Legion for Metropolitan Toronto and I'm also a representative for the Legion on the board at Sunnybrook hospital. I come this morning to ask you to consider the need of continuing to allow the veteran residents of facilities such as Sunnybrook Health Science Centre and other veterans' homes to purchase tobacco products onsite, such as in their tuck shops and in the Kilgour wing of the veterans' and in the Legion Toronto homes.

Many veterans in the Sunnybrook hospital have stopped smoking because of our health rules and our stop-smoking program, but we have 350 residents there in K wing, and 70 still smoke. Some of these veterans started smoking when they joined the army, like me, in 1939, at 18 years of age. We were given all kinds of free cigarettes, so we started smoking. But most of them have now quit and those over 70 have continued to smoke for 55 years. To expect them to stop is almost impossible, whatever programs we try to do.

Many of them are not physically able to go out and purchase cigarettes, and for them not to have a place like the tuck shop to buy them, the only thing that's going to happen will be to encourage contraband cigarettes to be sold throughout the hospital. We've had this problem with dial-a-bottle and we've been able to stop this, but cigarettes seem to be an impossibility to stop when there is not a place for them to purchase them. It's almost impossible to ask these people to go outside and buy cigarettes. Many of them have not got the ability to leave, and if we remove their opportunity to buy cigarettes from their tuck shops, this just means that contraband cigarettes will be in there. It's unfortunate they're already there and the veterans are paying a premium for these cigarettes on the weekends when there is no other available place to buy them.

So I've come this morning to urge you to reconsider Bill 119 and allow the veterans' hospitals, the veterans' wings of the hospitals and the veterans' homes to continue to be able to sell cigarettes in their tuck shops. That is my submission, and I hope you will reconsider it.

**The Chair:** The parliamentary assistant will start.

**Mr O'Connor:** I want to thank you first for coming and representing the Legion and its members.

The act currently doesn't allow for the exemption of sales in this type of situation because it's a health facility. Any exemptions that will be dealt with—and we're going to hear presentations from people like yourself—will be made as we get into the regulation process of the legislation. No decision has been made right now, so it's appropriate that you come to the committee and make a presentation. Thank you.

**Mr Jim Wilson:** Thank you, sir, for your presentation, because I think you raise a very good point. I'm astounded to hear what you said near the end of your presentation, that on weekends, when the tuck shop is closed, people are coming in and selling the veterans contraband cigarettes at a premium price. How often does that occur?

**Mr Currie:** I don't know how often it has occurred, but it has occurred in the last short while. I know that a nurse in an area where they were not supposed to smoke found cigarettes, and they must have been contraband because they had no stamp on them to say they had been paid for. So somebody brought in contraband cigarettes. I understand the veterans' service council chairman said they went up to \$7 a pack on the weekend.

**Mr Jim Wilson:** It's criminal in a number of ways.

**Mr Currie:** I haven't found any of these situations myself, but we're scared that this would be the norm if we can't buy cigarettes in the tuck shop. There's only 70 who smoke and we do have a smoking bylaw from North York and we have built smoking rooms. They're ventilated to the outside. There's no reason why the veteran can't go in there and smoke. We still have a little problem with the veteran who will not be told what to do, who wants to smoke in the areas that are restricted. But if we get veterans smoking in restricted areas like the rooms and the halls, then we have the danger of once again a fire. We've had this happen before when we didn't have restricted areas.

1100

**Mr Jim Wilson:** Good point. One of the reasons the government would like to ban the sale of cigarettes in health facilities and pharmacies is that they feel, in particularly the case of pharmacies, that it sends out a conflicting message to young people. The argument is made, of course, that it's a health facility and therefore it shouldn't be selling, even though it's a legal product, something that's detrimental to your health. Because the parliamentary assistant said that perhaps they would think of making an exemption for the veterans, I should ask: Do a lot of young people go by the tuck shop when they're visiting their grandpas?

**Mr Currie:** Not really, because the tuck shop is kind of a closed area. They do go by, but there are closed doors and they have to go through the doors.

The hours of the tuck shop are generally regulated and it's for veterans only, and the ruling that we have with our new smoking bylaw is that visitors are not allowed to smoke. If a visitor comes in, he must smoke outside or not smoke at all. The only ones allowed in the smoking lounges that we have are the residents that live there. So this cuts down on the public smoking in the hospital quite a bit. I imagine it's cut down a tremendous lot, if you hear the complaints.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I thank you so much for coming, Mr Currie, and may I thank you; you obviously have served your country well.

You said Sunnybrook and other veterans' facilities. Could you tell us how many you're thinking of?

**Mr Currie:** There is our Parkwood Hospital in London, and I have not talked to these people in London yet. They do have a tuck shop where veterans can buy cigarettes, or they do have their pub where they can buy cigarettes. Also, the Rideau Veterans Home has one, and our Legion home out in Island Creek does have a tuck shop and this is controlled. It's in the smoking or the residential area.

**Mrs O'Neill:** Is the tuck shop the only source in the facility, or would the coffee shop, for instance, also dispense cigarettes? It's limited to the tuck shops, is it?

**Mr Currie:** No, at the present time the coffee shop doesn't sell cigarettes, the cafeteria for the employees doesn't sell cigarettes, nor does the tuck shop over in the regular hospital sell cigarettes. So the only place that we're actually selling cigarettes is in the veterans' wing.

**Mrs O'Neill:** The area is limited, as you said? The employees can't smoke in that area?

**Mr Currie:** No.

**Mrs O'Neill:** Visitors? It's just the veterans?

**Mr Currie:** Employees or visitors cannot smoke.

**Mrs O'Neill:** And you're meeting all the bylaws of the local municipality.

**Mr Currie:** Right.

**Mrs O'Neill:** Thank you so much.

**Mr Currie:** I can leave with you the North York because—

**Mrs O'Neill:** Please do that.

**The Chair:** We'll get that at the conclusion of your submission. Mr McGuinty.

**Mr McGuinty:** Thank you very much for coming before us today, Mr Currie. I don't really have a question; just to tell you about one of the best jobs I ever had. After grade 13, I was an orderly for one year at the National Defence Medical Centre, and people were moved from the Rideau Veterans Home into the medical centre when they became more chronic care. I bathed veterans, shaved them, brushed their hair, helped dress them, everything, and of course the intention of all the care that was delivered there was to help maintain as much pride and sense of dignity for the patients on that ward.

There were very few things that you could do in a real sense that would give these men a great deal of enjoyment, but one of the things that almost all of them looked forward to was a cigarette, and I can recall that there was a man there by the name of Dr McIntosh. He was a physician, a patient, a veteran of the First World War. I said, "Dr McIntosh, you really shouldn't be smoking, should you?" I can recall what he said to me. He said, "How would you like me to turn you upside down and bounce you on your head?" This was particularly funny because he was confined to a wheelchair and weighed less than 100 pounds.

In any event, it was very obvious to me that this was one of the few pleasures these men had in life and I think it's important we make some provision for that.

**Mr Currie:** I was a young fellow. I went overseas and I didn't smoke. At the time, my dad was a member of the Royal Canadian Legion from the First World War, and the church and everyone sent me cigarettes. They were sending them for \$2 a carton at that time and they were very good because they came in nice square packets and I used to put them in my large pack and it made it nice and square on the side of my bed.

**Mr Perruzza:** I'd like to thank you for taking the time to appear before this committee. I think it's refresh-

ing, and we need to hear from people like yourself representing a group of people who—I don't think there's anybody around this table who would take issue with people who have served their country with diligence and with a lot of heart.

However, having said that, I'd like to go back to something you said about the expectation to stop and the kinds of things that cigarettes do and the fact that people can't leave to go buy cigarettes from outside and so on. It would seem to me that health care and substances that are the antithesis to good health, that run contrary to good health, somehow shouldn't have a place in the same place, because you can't on the one hand say, "You know we'd like you to do well and live a healthy existence," and at the same time and in the same place, say, "but it's okay for you to run your lungs ragged and drive yourself to an early grave." That to me poses a bit of a difficulty.

I appreciated your comments about people who have smoked for many years and that it would be difficult for them to go out and be able to purchase cigarettes. Certainly, we're not talking about kids and we're not talking about introducing new smokers into our society in your particular situation. I don't know how many 12-, 13- and 14-year-olds would visit your locations and at that point buy cigarettes.

That's something I think needs to be looked at and I'm pleased to hear the parliamentary assistant say there may be exemptions, particularly for those people who find it very difficult to leave the premises and be able to purchase cigarettes and so on.

I'd certainly like to sit down and look at that and try to develop options where we could say: "Fine, we understand. You've smoked for 50 or 55 years and you're not going to make an effort to stop now." If society were to bring pressure to bear on you, it wouldn't help. In fact, it might even harm your situation even more by denying you that thing you've had for so many years and have come to expect and desire and want.

I would sit down and look at that and try to develop ways that we could say, "Let's preserve the integrity of what health care's intended to do and let's not introduce into that system a substance that runs contrary to what health care and good health is supposed to mean."

However, I wanted to ask you a question. Can your veterans purchase all the daily staple items that people require on an ongoing basis in the facilities? I find one of the things that I have to buy a lot of are socks and toothpaste and razor blades and shaving cream and those kinds of things. Can you buy all those sort of daily items in your shop or do you have to go outside or do they have to be delivered somehow by other people?

**Mr Currie:** The hospital itself supplies practically all those needs, like razor blades, shaving cream, soap and all that. The hospital supplies that to the veteran when he's in the hospital. Any other shortage that he needs, all he has to do is phone me and one of the legionnaires will be up there in an hour with more than he can handle.

If you recall, someone wrote in the paper back a few years ago that the veterans didn't have any soap. Well, we were swamped with soap, shaving cream and razor



blades to the point that we didn't have a place to store them. All those things are there available for them. All those things that you're talking about are supplied and there's no shortage of them.

Daily or monthly I have a meeting there with the veterans' council and if they require anything, the Legion supplies it right away. There's no problem.

1110

**Mr Perruzza:** What you're saying is that on a daily basis, if people needed cigarettes, cigars, tobacco or those kinds of things, they would just ask you for them and they would be delivered by you and sold in the—

**Mr Currie:** Not cigarettes and tobacco. We don't deliver that any more. We stopped doing that because the problem is that if a group of people come in with cigarettes, they don't know who smokes or who can't smoke and the nurses have brought in a program there of non-smoking. A lot of these people are on oxygen and have lung problems and the nurses will not let them smoke. For those who can smoke, the nurses generally control it, because if a person is unable maybe to look after himself, the nurse sees that he goes to the lounge and she supplies him with the cigarettes or what is necessary. He buys the cigarettes because we no longer buy them.

**Mr Perruzza:** Getting back to something my colleague and good friend Mr Wilson was talking about, this contraband thing, people coming in and selling these contraband cigarettes, how do you regulate that? You're saying, "If we deliver them, we can't tell you who can smoke and who can't smoke and the nurses are the ones who regulate it," and so on and so forth.

Some guy shows up there and wants to sell cigarettes illegally, and cheaper I may add. Obviously, that raises a question in my own mind: Do you go into the shop and buy them at a regular price, whatever the regular price is nowadays—I imagine it's well over \$7—or do you buy them contraband for \$4 or \$5 a pack, and how would that change in any way if you were to eliminate the shop?

**Mr Currie:** We have security and the security officers are watching who goes up to these floors. If a guy comes in there and says he's visiting and he's trying to sell cigarettes, we had this problem with alcohol with the Dial-A-Bottle, and we had to stop these people from even coming into the building. This would be the same thing with the contraband cigarettes. We would have to stop it because if a person's, say, up on the third floor and he has a problem with not being able to control himself so he can light a cigarette, and he gets contraband cigarettes and they supply him with matches and a lighter, the first thing you know we have somebody with a fire. This has happened many times in the past before we started this program of non-smoking and controlling the smoking.

**Mr Perruzza:** Thank you very much. You were very helpful.

**The Chair:** The parliamentary assistant just had one final comment.

**Mr O'Connor:** I just wanted to clarify for you that the act, as it's currently written, doesn't allow for the exemption of the sale of tobacco, but for smoking to take

place. Your comments coming to this committee are certainly going to be useful to us. I think all the discussion we've had in some of the other areas that my colleagues have brought up will help us as we take a look at this issue. As to the nurses having control of the tobacco substance itself with the legionnaires who are still smokers and those who perhaps shouldn't be smoking because of health risk, all of that will be useful for us as we try to decide where we go from here.

**The Chair:** You mentioned that you had with you, I believe, a copy of the North York bylaw. I think that would be of interest to members. I'll have the clerk get that from you. Thank you again for coming before the committee today.

#### PHARMA PLUS DRUGMARTS LTD

**The Chair:** I call upon the representatives from Pharma Plus Drugmarts Ltd, please.

**Mr Jim Wilson:** Mr Chair, while we're waiting for our next witnesses, I wonder if I could have unanimous consent to correct someone else's Hansard record.

**The Chair:** Probably not. I don't think I'll even put that to a vote.

Welcome to the committee. If you would be good enough to introduce yourselves, then please go ahead with your presentation.

**Ms Rochelle Stenzler:** Thank you for meeting with us this morning. We will take only a few minutes to explain Pharma Plus Drugmarts' position on Bill 119, the proposed Ontario tobacco act, and our reasons for that position. To start, however, you should know a bit about who we are, just on our own and as our company.

My name is Rochelle Stenzler. I'm the president and general manager of Pharma Plus Drugmarts. I am also an Ontario registered pharmacist with nearly 20 years of experience in community pharmacy. With me today is Tim Carter, who looks after public affairs for our company.

Our purpose is to outline the Pharma Plus position in areas affected by the proposed Ontario tobacco act. We also welcome this chance to answer any questions you may have.

Pharma Plus Drugmarts is Ontario's second-largest drugstore chain, with 133 stores in this province and another 10 in Manitoba. We are a wholly Canadian-owned company and an autonomous subsidiary of the Oshawa Group. Each of our stores is corporately owned, not franchised, which means nearly 3,000 Ontario residents are Pharma Plus employees, working in our stores and our Mississauga head office.

Although Pharma Plus is a relatively new name in communities across the province, we have a long history in Ontario. Past drugstore chains, such as Tamblyn Drugmarts, Boots Drug Stores, Safeguard drugs and Drug City are now represented under the Pharma Plus banner. Our stores are moderate in size, averaging about 5,000 square feet, with a product mix which covers over-the-counter medications, health and beauty aids, household supplies, confection, stationery and other sundries.

Of our total selling area, less than 10%, or under 500 square feet in each store, is devoted to the prescription



department, with the balance distributed among the other product lines I mentioned earlier. In other words, only a small section of a Pharma Plus Drugmart is perceived by our customers to represent a health care facility. They see the majority of our store as a convenient place to buy a wide range of merchandise.

To begin, it is important to acknowledge that we support several of the stated tobacco strategy objectives advanced by the Ministry of Health. Specifically, we wholeheartedly endorse Bill 119's intent to discourage children and adolescents from starting smoking, to reduce the overall use of tobacco and to decrease public exposure to secondhand smoke.

However, we strongly oppose paragraph 4(2)8, the proposed ban on tobacco sales from drugstores. It is excessively punitive and inflicts unfair hardship on our segment of the retail industry. Moreover, we are convinced it will prove to be totally counterproductive to the very objectives you are trying to achieve. I will explain why we oppose banning tobacco from all drugstores and at the same time discuss how we believe such a ban would affect tobacco use and total market consumption.

Let us concede at the outset that tobacco does generate a small profit in many of our stores. However, our gross margin on cigarettes is only approximately 10%, not counting any losses to theft. This 10% is less than half the typical store average gross margin rate, from which we must pay all our total operating expenses before any profit can be realized. More important than the slim margin is tobacco's contribution to our product mix and its ability to attract other sales. Furthermore, it is important to consider the general economic environment in which drugstores operate and then examine the specific role of tobacco in that business.

The recession, despite expert proclamations to the contrary, continues to grip this province. Official unemployment is pegged at roughly 11%, while the federal government in January suggested that this figure in fact understates reality. It fails to take into account those who have given up looking for work or who have settled for part-time employment when they really need full-time. Whatever the actual number may be, clearly we have a lot of people out of work. It follows then that if they don't have jobs, they don't spend as much money in any store, including the drugstore.

1120

At the same time, even people who are working are spending less. Consumer confidence remains feeble and the effect can be seen clearly in sales results at most retailers. As an industry, we continue to be hit hard and are struggling today for our very survival.

A natural result of decreased consumer spending is the recent dramatic increase in competition. Each player in the market is trying to find a way to attract those scarce customer dollars into their stores. We see traditional drugstore products being promoted in non-traditional outlets such as department and hardware stores as they work to protect and expand their market share.

At the same time, most retailers have been forced to reduce prices to try to win business. Although you may

sell almost as many items using this strategy, your margin is severely impacted. The overall result of this competitive activity has been to encourage consumers to be extremely value-conscious and frequently completely won over by price consideration alone.

Furthermore, the drugstore segment has toiled with additional challenges not faced by other retailers. We have been hit by both the social contract and ongoing government efforts to contain the costs of the Ontario drug benefit program. For example, our professional fee for prescriptions billed to ODB had been frozen since June 1990 at \$6.47, while many of our costs of doing business have increased substantially. In September 1993, the social contract rolled that figure back to \$5.86, further reducing our profitability.

In the past two years alone, the Ministry of Health has de-listed more than 100 drugs from the drug benefit program and instituted other significant changes to the extent of coverage offered. While these actions have saved the government more than \$100 million, they have cost drugstores dearly in lost sales. Many patients simply cannot or will not buy the products if ODB doesn't cover them. Others may buy them more sparingly or less often, depending on their personal finances.

Compounding the problem is ODB's consistently slow payment of outstanding accounts, which impedes cash flow and viability even more. At this instant, the Ontario government owes Pharma Plus Drugmarts \$8 million and is taking an average of 45 days to pay for prescriptions we fill on its behalf.

Taking their cue from ODB, insurance companies and other drug plan administrators are also putting pressure on pharmacy to reduce our professional fee. When added to other factors, such as large-quantity prescriptions and new, more expensive drugs, the overall financial performance of the prescription department of most drugstores is deteriorating rapidly.

In fact, our gross margin on prescriptions has dropped nearly 20 percentage points in the last decade, and for 1993 alone is a full percentage point lower than it was in 1992. If we had to depend on our prescription sales alone, in many locations we would not make enough money to keep our doors open to the public.

To remain economically viable, therefore, many drugstores rely more and more on their front-store, non-prescription sales, but as we've already discussed, market factors are reducing the profitability of this segment of the store as well. Without a profit, there is no reason to keep a store open. It cannot run as a public service.

However, the public does benefit from having a dependable drugstore in the community. Where else can a person get medical advice on the spot, without an appointment, at any hour of the day or evening? Where else can they get that advice at no cost to either themselves or their medical plans? Many times, a patient will require no medication whatsoever for the condition they describe and pharmacists therefore receive no compensation for their time and counsel.

The Ministry of Health has recognized and exploited this free service of community pharmacy in its new pilot

program in and around London, Ontario. By discouraging patients with cold symptoms from consulting their physician, the government hopes to save \$3 million in OHIP billings. As the ministry knows, many of those patients will consult their pharmacist and receive advice such as, "Rest in bed and drink plenty of fluids." In case after case, no products will be sold, no profit will be made. Free, on-demand medical advice is part of the contribution only a profitable pharmacy can offer the community.

In my opening remarks, I mentioned that Pharma Plus operates 133 drugstores in Ontario. Eleven months ago, appearing before a government committee dealing with this same topic, I was able to say we ran 136 stores in this province. Since then, we have closed six and opened only three. If you have any doubt that the economy and the other factors I have talked about are taking their toll, I suggest you speak with any of the almost 50 ex-employees from stores we were forced to close in 1993 whom we could find no place for in other stores.

Further, you would find it interesting to speak with some of their former customers and patients who have had to find another, often less convenient drugstore to meet their needs. They can tell you in detail of the hardship caused by these difficult times.

What does all this have to do with Pharma Plus selling tobacco products? Let me explain.

Traditionally, tobacco products have been low-margin items for drugstores, priced, as I mentioned earlier, at levels only about 10% above cost. In addition to any value they have on their own, their major advantage from our perspective has been their ability to draw customers into our stores.

A recent Coopers and Lybrand study commissioned by the Committee of Independent Pharmacists and presented to you yesterday shows that for every dollar smokers spend on tobacco in a drugstore they spend a further 37 cents on other items.

Coopers's very conservative estimate suggests we will lose only 25% of those companion sales or roughly 10 cents for every lost tobacco dollar. For example, assuming a carton of cigarettes sells for about \$40 before PST and GST, we will lose at the very least a further \$4 sale to each lost tobacco customer. Forgoing the small profit on the tobacco sale therefore is only part of the penalty we will pay for this new law. We will also lose the profit on the companion sales.

Of course, if they cannot buy it from us the customers will buy their tobacco from other sources, including retailers who have not been singled out by this law. In many cases, these will be competitors who offer many other products which we sell, such as toiletries and beauty aids. What chance do we have that our smoking customers will come back to us for these or other front-store items once they are already inside such a competitor's store? Worse, the next time they need one of these products, there is a distinct risk they will return to our competitor even if they do not need to buy tobacco at that time. Clearly, we can expect ongoing erosion of our sales beyond merely tobacco products.

Our store lease agreements are another factor that complicates the tobacco picture. In our stores, we pay a percentage of our gross sales as part of our rent. However, to accommodate the low margin on tobacco, most of our leases provide for a reduced or even zero percentage to be paid on those tobacco sales. If we no longer can sell tobacco and somehow are able to find products to sell in its place we will be hard pressed to replace the lost sales dollar for dollar. Moreover, for any extra sales we can generate, we will find ourselves owing our landlords a higher rent as a percentage of sales.

It's not difficult to predict what effect losing more business and paying more rent will have on our stores. In the extreme, we will have to close a number of them. In fact, following a thorough store-by-store analysis, we can give a cautious estimate suggesting at least 10 of our stores will become potential closures if we lose tobacco from our product mix. That represents a loss of about 90 full-time and 80 part-time jobs. In other words, in our company alone, banning tobacco sales will cost 170 jobs in Ontario. Moreover, even in the stores which remain open, we will have to decrease staff hours to varying degrees.

The majority of Pharma Plus store employees are represented by one of two unions: the United Food and Commercial Workers International Union or the Retail, Wholesale and Department Store Union. That means we have a negotiated procedure to follow when hours are decreased. In the situation I've described in stores that we keep open, some full-time employees would drop to part-time and see their benefits reduced proportionately. At the same time, they would displace other part-timers, thereby causing further job loss. Clearly, not only would Pharma Plus experience yet another blow to our business, but significant numbers of our employees would lose their jobs if the government enacts this legislation. At the same time, closing any drugstore reduces the public's access to no-cost, front-line health care advice.

Some sceptics will point to other drugstores which discontinued selling tobacco products and yet remain in business today. A close examination of these situations often reveals that these stores were typically quite small in terms of retailing selling space, had low tobacco sales to start with, did not achieve a high level of companion sales or were able to find a way to replace the attraction and margin that tobacco provided in their stores. One of the keys in these situations was that the retailers made the decision to discontinue tobacco sale of their own free will. Furthermore, they were able to select and control the timing of this change to their business.

#### 1130

Looking back over the last two to three years, we have seen the sales of cigarettes plummet from our stores. In fact, our tobacco sales for 1993 were less than half of what they were in 1991. Ignoring the financial impact, this would be wonderful news from a health promotion point of view if it represented a corresponding drop in the volume of tobacco being smoked. It does not.

What it represents is the volume of tobacco now being purchased from other sources, especially the black market. A study conducted by the forensic research firm



of Lindquist Avey Macdonald Baskerville and recently presented to this committee showed that more than one quarter of all tobacco consumed in the province is now purchased on the black market. Alarming, the contraband tonnage has increased more than 50 times in seven years.

We can see this element of the marketplace is completely out of control. Any new rules which the government may impose to attempt to achieve its objectives will mean little in the face of advancing market chaos. For example, while drugstores and other responsible retailers carefully enforce age restrictions on the purchase of tobacco, black market vendors sell to anyone, regardless of age. As the Lindquist Avey study showed, underage smokers already rarely buy their tobacco from drugstores because we are among the best enforcers of the province's age restrictions.

When you consider that the average carton price of cigarettes on the illicit market is roughly 50% of the legal retail price, including GST and PST, it is not hard to understand the drop in the legal share of the market. No wonder the black market pricing has contributed to an increase in consumption, the first reported by the federal Ministry of Health in years. Any further action which serves to enlarge the illegal part of the market will only serve to accelerate this trend and damage the government's ability to realize its objectives of reducing consumption.

As mentioned, the Lindquist study showed drugstores to be among the best retailers at obeying the law by stocking only legal, tax-paid inventory. It also reported finding evidence of an increase in neighbourhood non-pharmacy competitors carrying dual cigarette inventory. In this situation, legal product is generally sold to unknown, non-regular patrons while familiar, trustworthy customers receive contraband inventory. The contraband customer gets a lower price and the retailer receives a higher margin; in other words, contraband product is now being sold by existing retail outlets, some of which are neighbourhood competitors to our stores.

Should our declining group of regular cigarette customers find themselves unable to buy tobacco at the drugstore, they will in many cases turn to another local store. If this retailer is one who stocks dual inventory, he probably will sell this new customer legal stock initially. As the customer becomes a regular, the retailer will then likely move the customer to contraband inventory at a lower price and a higher profit.

Instead of retail supporting government's objectives, some segments may actively move to the contraband market for their own profits. In this way, the proposed tightening of rules for the legitimate portion of the market will serve to expand the illegal side, decrease government control, diminish greatly needed tax revenues and ultimately prevent realization of the government's objectives.

We can see that rather than contribute to the ministry's goals, a drugstore ban will actually work against its achievement. In essence, the proposed ban will remove the most supportive section of the retail market in the fight for control over the sale of this product. More tobacco will be smoked, young smokers will have greater

access to cigarettes through the expanded contraband market, and there will be no reduction in secondhand smoke.

In closing, I would like to restate our position. Pharmacists are dedicated professionals committed to helping their patients maintain their health. Selling tobacco in the same retail outlet does not compromise that professional role, and its sales help preserve the financial viability of many drugstores while sustaining related employment.

Removal of tobacco at this time would cause needless economic hardship. Government intervention in the manner proposed is contrary to the principles which foster a free-enterprise, market-based system. Previously presented research has identified drugstores as being particularly helpful in enforcing age restrictions and avoiding dual inventory or contraband merchandising. As a result, Pharma Plus believes a legislated removal of tobacco from drugstores would be inconsistent with promoting the government's stated tobacco strategy.

Thank you for the opportunity to present our views.

**Mr McGuinty:** Thank you very much for your presentation and for a comprehensive overview of the impact Bill 119 would have, and I guess a good review of what government has done over the years to pharmacies.

I've got to ask you this question, though: One of the impressions we are left with is that any of the large chains that are against 119, that particular provision, are really lackeys of the smoking manufacturers. Are you owned in any way by a tobacco company?

**Ms Stenzler:** Not in any way.

**Mr McGuinty:** No connection?

**Ms Stenzler:** No connection. We're Pharma Plus and we're owned by the Oshawa Group Ltd.

**Mr McGuinty:** Where do you rank in terms of the size of chains in the province?

**Ms Stenzler:** Second in number of stores.

**Mr McGuinty:** How many employees, again?

**Ms Stenzler:** Three thousand.

**Mr McGuinty:** So you're not connected to a tobacco company?

**Ms Stenzler:** Not at all.

**Mr McGuinty:** The second thing I want to ask you is, we've heard that some pharmacies, chains even, have chosen voluntarily to no longer sell tobacco products in their stores and they have been able to cope financially quite well. Why couldn't you do the same?

**Ms Stenzler:** I think the situation you're speaking of is different for every single retailer. There is no taking all stores and putting them in one pile. Within retail pharmacy today, there are stores that range in size from 500 square feet to 10,000 square feet, and even larger if you get into the discount drug market. In looking at that, there are drugstores very clearly that had a very low reliance on tobacco at any time in their existence, because the sheer size of their store in many cases doesn't allow it. They are truly pharmacies with very minimal amounts of retail other product in the store. Therefore, the majority of the stores that have taken that decision have done so



based on their economics for their situation.

Within our chain, we also have some stores that do not sell tobacco and those decisions have been made based on each store on its own circumstance.

**Mr McGuinty:** Do I understand it that if someone in the store chose not to sell tobacco, they could do so?

**Ms Stenzler:** No, the impetus for the decision came from a business reason combined with looking at the environment in which we operated and whether or not it was required or not required to that store's mix. We have one location in London where when we pulled tobacco out—we are beneath where there are medical locations—the doctors were the ones who complained when we removed tobacco.

**Mr McGuinty:** I'm wondering about the job losses here. I gather a lot of that is due to the fact that this comes in, this comes down like a hammer, right away. Could that impact be moderated somehow if this deadline was delayed?

**Ms Stenzler:** I'm sorry. I missed the beginning of your question.

**Mr McGuinty:** How many job losses did you project?

**Ms Stenzler:** It is 90 full-time and 80 part-time.

**Mr McGuinty:** And those would be experienced in the event this provision came into effect, as scheduled, under this bill?

**Ms Stenzler:** It would come into effect as the store probably normalized in its new existence and could not survive based on the dollars it would generate, both in volume and profit.

**Mr McGuinty:** What if that deadline was moved further down the road, with more time to adjust?

**Ms Stenzler:** That would certainly help retailers get conditioned to what they have to deal with in order to accommodate that. I said in my presentation we've already dropped about 50% of our volume. We've had to manage that decline in volume quite carefully over the last couple of years, even to survive to this point. It has been very difficult. The key thing that people tend not to understand or realize is that tobacco is stored behind the checkout in a pharmacy. If you remove tobacco, you're going to get very little benefit of that merchandising space in terms of replacing those sales.

1140

**Mr Jim Wilson:** I want to explore three areas. One is along the lines of what you were just commenting on. Actually, that argument has been turned around by some presenters, and that is that your tobacco sales have been going down—you mention a 50% decrease since 1991—and that therefore if the government goes ahead and bans you from selling tobacco altogether, you should be able to handle it; you've been handling it so far. Frankly, coming from a retail family myself, I know the answer, but I'd like you to further explain it to members of the committee.

**Ms Stenzler:** As I've said, obviously what's gone on in the last couple of years has not been driven by anybody's desire. It has been the shift in the marketplace from the traditional retailer. As I said, from research it

appears it's going into the black market. Therefore, retailers have literally been living day by day and doing their best to sustain that decline in volume, and although it has been, I'll say, fairly dramatic, it has still been two years in which it's gone down 50%. That is quite a difference from taking 100% out in the balance of a year.

**Mr Jim Wilson:** Just on that latter point, because it was unfortunately missed by the media during the Coopers and Lybrand presentation the other day, what I think failed to be pointed out was that it's going down everywhere because of the contraband. It's not like your decrease in volume since 1991 in cigarette sales was because consumers decided to stop buying cigarettes from drugstores. You could say the same for the other shops along the mall that sell cigarettes.

**Ms Stenzler:** Exactly. In fact, all retailers will report drops in the same magnitude as I've just reported for our chain.

**Mr Jim Wilson:** The other thing I wanted to explore, and I'm very pleased that you had it in your brief, is in terms of customer perception of the drugstore. I said on the first day of the hearings that as a young person, my perception of the drugstore was a place where you could get prohibited products, or wanting to revise that language, restricted products. I had no other reason to go to a drugstore unless my mother sent me or I was doing a science project. That's about the only time I remember going to a drugstore. It might have been because we owned a grocery store and I didn't have to go to the drugstore for anything else, but it also might have been that drugstores in those days, not too many years ago, in a small town like Alliston were really just the pharmaceutical counter. It was profitable and that's all you really needed.

Can you give us a feel for your customers' perception now? You mention that less than 10% of your actual retail space now is the drug counter. Do you have any other proof to offer with regard to your customers' perception of your store as a retailer?

**Ms Stenzler:** The proof we have is that we have done research in the past. In the last five or six years, since there's been the focus on tobacco, we certainly have undertaken significant research to make our own decisions in terms of, could we benefit in other ways if we made certain business moves?

The research tells us that if you prod customers and talk with them, as opposed to just asking the question, "Do you think a drugstore should or shouldn't carry the product?" you will clearly find out that they look to a drugstore for far beyond the prescriptions and OTCs. That is something very much of years gone by. That was the traditional core, the corner drugstore, and there are still probably close to 1,000 of the 2,300 stores in Ontario that are very much like that. Those are the people claiming to be the Good Samaritans, but they had very little reliability or mix of tobacco to begin with.

**Mr Jim Wilson:** I guess from the very beginning—I heard it again on the radio yesterday, somebody once again saying that if the government really wanted to restrict the sale of tobacco or limit its consumption by young people, why in the world wouldn't they put it in

a store that already plays that role with respect to prescription drugs and other harmful substances? Could you just comment on that, because it seems to me, trying to use a little bit of logic looking at this section of the act, that the section defies logic.

**Ms Stenzler:** In many ways you are leading to something that probably from a sense standpoint should be thought of, and that's very much that pharmacists today are the keepers and dispensers of all other addictive products. If you look at this, that tobacco is an addictive product, one could turn around and say it should only be sold from behind the prescription counter by pharmacists and maybe even by prescription. That could be looked at as a flip side. We have all the narcotics back there. They're more addicting and in many cases could create more trouble. Many regular drugs could create the same kinds of difficulties with health hazards and certainly we are the keepers of those products.

**Mr Jim Wilson:** Finally, it is suggested by a number of groups that perhaps the next step in the next decade is to restrict the sale of tobacco products to LCBO stores or beer stores, and to set up a tobacco control board or to give new responsibilities to the liquor control board, which to me seems like a great big hassle when you've already got pharmacies which, as you say, are already controlling addictive products.

I suspect the government doesn't want to take the heat from the thousands and hundreds of thousands of corner store owners if it were suggested that actually pharmacies should be the only ones selling tobacco.

**Ms Stenzler:** I think I'll ask Mr Carter, actually, to respond to that one.

**Mr Tim Carter:** I think that what you find with the pharmacies having trouble financially with the removal of tobacco, you might extend that argument for other stores that rely on it.

One of the things that would come forward, I think, in your hearings on that would be what's happening with the market. The market right now is moving to a Quebec situation which is contraband, to a majority of it. With the United States next door, you would advance that by controlling it, and you would have to address the smuggling issue to execute that plan.

**The Chair:** We'll move on to our next questioner. I'll just comment and this will show my age, but I always remember that the reason you picked this or that pharmacy was the soda fountain.

**Mrs Haslam:** What's a soda fountain? Could you explain that to me? I'm not sure what a soda fountain is.

**The Chair:** They were great places.

**Ms Stenzler:** Actually, Tamblyn Drugmarts were the ones that had the soda foundations.

**Mrs Haslam:** What's a Tamblyn?

**Ms Stenzler:** It's two precursors and a Pharma Plus.

**The Chair:** Sorry, I digressed and got the committee off on another tangent.

**Mr Tony Martin (Sault Ste Marie):** I also appreciate the fact that you've come forward today. Certainly you are a major player in the area of how we dispense drugs

in the province and somebody who's going to be impacted very clearly by this legislation, and it's good to hear from you. It's also good to hear you state clearly that you are in fact a retailer, because the discussion that's going back and forth here in many instances is, are you a health practitioner or are you a retailer? That seems to be a somewhat grey area and we're trying to come to terms with some of that.

I also appreciate the comment you made about the fact that pharmacies are, for the most part, all of them I guess, not getting into the contraband sale of cigarettes. I think that's something that should be lauded and we thank you for your contribution in that very difficult challenge that we're all facing at the moment around the question of cigarettes.

However, I want to focus, since you did come as a retailer, on that particular issue in my questioning here because I want some clarification from you.

Just to go back a bit, the basic premise of this legislation is that a pharmacy is a health service, and most of that service or a good chunk of that service is paid for by government. We may have to agree to disagree, I guess, on the issue of whether selling tobacco products beside the health products is inconsistent in terms of a message and what that's about.

However, I wanted to focus, as I said, on the retail section. I remember sitting at a table here not so long ago around the question of Sunday shopping and talking about fairness and level playing fields and all that kind of thing, and sitting at home in my office in Sault Ste Marie and listening to all the corner stores coming in and telling me how unfair it was, and how it was going to take away from them a market share by allowing the Pharma Plus and the Shoppers Drug Mart and all that to get into the business of being open on Sunday.

We went ahead with that legislation and they had to deal with that. I guess they would say that wasn't fair, but that's the way it was in those days, and you were certainly in favour of that at that time.

**1150**

The other thing I suggest to you is that you have in this instance a monopoly on a host of products here. Would you see it, given your argument, as being fair for us maybe to extend the opportunity for corner stores to get into the business of dispensing drugs in order to make it an equal or a fair or a level playing field in terms of the competition here that we're talking about? Those are my questions.

**Ms Stenzler:** If I could, I'd like to clarify some of your comments. Firstly, drugstores have always been allowed to be open Sundays.

**Mr Martin:** Drugstores, yes.

**Ms Stenzler:** Pharma Plus Drugmart is an average 5,000-square-foot store. It was a 7,500-square-foot rule. I don't think it was an issue at all. In fact, almost all retailers, traditional drugstore retailers, have always been able to be open. There were very few that fell into the exempt, over 7,500 square feet. That's just a matter of clarification.

Beyond that, with respect to your question, I want to



be quite clear. There's a very distinct difference about people coming forward and saying, "You already corner the market or are the only ones who can have prescriptions or OTCs of certain kinds." That is not true. Anybody who meets certain regulations and requirements can become a registered pharmacy. In fact, that's part of the difficulty in this province, that there are not very stringent rules on what it takes to be a pharmacy.

If you go through the trouble, you hire a pharmacist, you have running water, you have a dispensary laid out as they say and you have a library, somebody from the college of pharmacists will come in and say, "You're a pharmacy." People are not precluded from getting into that business should they so want to.

This is taking a legal product and restricting it from one segment of the market. That's significantly different in my mind from saying that today pharmacies are the only ones who have dispensaries. Anybody can do that. It's in fact why department stores and other stores are starting to put in dispensaries.

**Mrs Haslam:** With all due respect, when you answer my colleague's question, you call yourself a drugstore: "Drugstores are open on Sunday." "I'm a drugstore." When you answer Mr Wilson's questions, you are a retailer. You talk about the jobs and the products and you're a retailer. That's the question here for me, looking at the health issues around this.

I'd like to deal with you as a pharmacist. As a pharmacist, does smoking have a negative effect on health?

**Ms Stenzler:** Yes.

**Mrs Haslam:** Oh, I'm glad you're brief. I get long answers from these other people. Do you, as a pharmacist, believe the ultimate goal of Ontarians is to move towards a tobacco-free society?

**Ms Stenzler:** Yes.

**Mrs Haslam:** Now, you're a pharmacist. Okay, I want to go into a little bit about this retailer versus pharmacist. As a retailer, you can hire a pharmacist. Does that make a pharmacy? You talked about what makes a pharmacy: running water, a library. You hire a pharmacist. Is that correct?

**Ms Stenzler:** Correct.

**Mrs Haslam:** As a retailer, in order to put the word "drug" in your sign, you have to hire a pharmacist.

**Ms Stenzler:** Correct.

**Mrs Haslam:** Okay. So there I think is the major problem. The retailers are saying, "We want to sell for profits." The pharmacists are saying: "It's a conflict for me. I'm in a health facility." When the pharmacists came before other committees, they said: "We are health practitioners. We want to be governed as a health practitioner. Me, health practitioner." Now we find that retailers are saying: "No, I'm a retailer. I'm a businessperson. I have a profit line." I think there's a definite conflict there.

In your position, since 10% of your store space is a drug counter, would it be easier for you to say, "Goodbye, drug counter," for 10% of your store space, or would it be easier for you, profitabilitywise, to say

goodbye to the tobacco products? Ultimately, you have to make that decision. You're in a strange situation where you're a pharmacist-retailer, I understand. You're going to have to make a choice. If you were given that choice, which one of those two would you choose? Are you a retailer or a pharmacist?

**Ms Stenzler:** I'll start by saying I'm both and I don't see any reason why you can't be both. We have pharmacists who work in that 10% of the store and some of the front-store areas as well, and then we have clerks and the regular retail environment that surrounds any other normal retail environment in the balance of the footage. That's my first answer: I'll say, if you're saying am I a retailer or a pharmacist, I'm both.

**Mrs Haslam:** I think the time has come for a decision, and what we're looking at here for a lot of people. As a pharmacist, you must follow certain rules and regulations. You take an oath. You are in the business of promoting health. As a conflict of interest, it must be difficult to promote healthy living when you know, as a retailer—or the retailer that hired you as a pharmacist is making profit in one way or another off a poisonous product that is detrimental to health.

I think the question is the presumption that financial profitability supersedes the health policies that we as a government are trying to put in place with this particular piece of legislation.

**Ms Stenzler:** I'm not sure I can say I totally agree with your comments—

**Mrs Haslam:** That's easy. I don't agree with everything you say.

**Ms Stenzler:** —and that's fine. I think the key here is this: It's interesting you raised this, because I've been through many rounds of negotiations with the Ontario Ministry of Health. It's interesting that the ministry, at that time, continued to point out to pharmacists that they don't need X amount of money for a professional fee because they have the whole rest of their store to help them make money. So it's very curious that we sit here today and we're being told that we can't be both, yet when the ministry doesn't want to pay us a professional fee that's adequate to reimburse us, at that time it's a valid reason.

**Mrs Haslam:** That's a valid point and I've heard that point before. I understand your concern in dealing with that. If this legislation puts you in a position where you are either a pharmacist or a retailer, I would perhaps put forward the view that as a pharmacist you may have a better chance at negotiations when the time comes.

**Ms Stenzler:** I don't think we're here to debate that today.

**Mr Jim Wilson:** They don't negotiate.

**Ms Stenzler:** Yes, everything is unilaterally imposed, so we don't negotiate with the ministry.

**Interjection:** The pharmacists walked away from the table.

**Ms Stenzler:** That was social contract; separate negotiations.

**The Chair:** One brief question, and Mr McGuinty has



a supplementary which I'll allow as well.

**Mrs Haslam:** Mr Chair, you're such a wonderful Chair, and you're so fair and I do—

**The Chair:** Flattery will get you everywhere.

**Mrs Haslam:** Oh, I hope so. It doesn't get me much anywhere else.

**Interjection:** Much better than the one we had yesterday.

**Mrs Haslam:** Much better than the one we had yesterday.

I was interested in your comments about over-the-counter because, to tell you the truth, I know that when you talk about the things that were removed from the drug formulary, we are talking laxatives, we are talking things that are available over the counter, antihistamines and some cough remedies and certain of those things. Are you saying that you were not able to pick those up in over-the-counter sales? That to me is a surprise, because in one way it shows me then, how necessary were they when the taxpayers were paying the shot versus how necessary are they now? When you talk about \$100 million that the government is saving, let me remind you that is a saving to taxpayers. I was interested to hear you say you're not picking up the profit?

**Ms Stenzler:** I think it's what I said in my paper. When you remove something from being covered by a drug plan, it is then up to the consumer that they have to be out of pocket. Some people just can't afford it. Some of the seniors cannot pay for it, and those that have to get it are certainly getting it, but they tend to—

**Mrs Haslam:** It's my understanding that they can go back to the doctor and there are other things on the formulary that are available to them.

**Ms Stenzler:** That may be the case. My point is really that some of the sales, yes, have been transferred into the OTC segment, but certainly, again, it has not been a matched situation, where if someone was getting it that way, they aren't getting it the other way.

1200

**Mr McGuinty:** I just wanted to take advantage of your presence here. As you can see, a lot of the debate centres around the symbolic value and the perceived paradox, for some people, as to your selling tobacco products at the same time you are supposed to be a health care deliverer. We've had the opinions of various members of the committee here, and that's fair enough, and then we've heard from pharmacists and from the anti-smoking groups. With respect to all of those people, I think the important group is the ordinary person on the street. What do they think of when they think of a pharmacy? Not what I think and not—we're into this bureaucracy here and understanding it.

Do you have any breakdown? Of the people who go into a drugstore, how many go there for prescriptions and how many go there for other items? Maybe another breakdown is, how many go there for non-health-related reasons?

**Ms Stenzler:** Without having my company's statistics in front of me, first of all, the figures will vary by store,

by location. If it is a mall location or a high-traffic location, the majority of customers come for the front of the store. If you're a corner neighbourhood location in a strip plaza, or freestanding on a street, you may have more people come to the back of your store.

There is also some cross-pollination between the two areas, so their primary destination may be one part or the other and some of them do tend to make auxiliary purchases when they're there. So the numbers vary. It's just like, can you close your store or eliminate tobacco? Every store is different.

**Mr Carter:** Can I answer the rest of that question? We don't feel, as part of the health industry, that making a decision on behalf of our customers whether they engage in a product or not makes us any purer. We haven't looked towards corporate censorship on that point, nor do we think that government censorship on that is appropriate in this case, particularly in light of the fact that drugstores will actually help achieve the government's objectives, and without drugstores, those objectives will be harder to realize.

**The Chair:** Thank you both very much for coming before the committee with your presentation and answering our questions.

The committee will then stand adjourned until 2 o'clock. If I could just ask members, we have a very full afternoon, so perhaps we could start at 2 o'clock sharp.

**Mrs O'Neill:** When will we have the decision about the 23rd or the 24th?

**The Chair:** I will repeat the decision that was made at the beginning of our session at 10 o'clock sharp this morning. At that hour of 10 o'clock sharp, the committee decided that it would meet on February 24. It further decided that for clause-by-clause, it would be on Monday, Tuesday and Wednesday, March 7, 8 and 9, beginning at 1 o'clock on Monday, March 7.

The committee stands adjourned until 2 o'clock.

*The committee recessed from 1202 to 1402.*

#### ADDICTION RESEARCH FOUNDATION

**The Chair:** Our first witness this afternoon will be from the Addiction Research Foundation, if you'd be good enough to come forward please and introduce yourself for the purposes of Hansard and the viewing audience out there. We have a copy of your paper.

**Mr Mark Taylor:** Thank you, Mr Beer. I'm Mark Taylor. I'm the president of the Addiction Research Foundation which, I imagine you all know, is an agency of the government of Ontario. My colleague conferring there, if I can get her attention, is Dr Roberta Ferrence, who is a senior scientist of the Addiction Research Foundation and also—correct me if I give the wrong precise title, Roberta—the director of Ontario's tobacco research unit that was recently established.

I will be setting out the position of the Addiction Research Foundation on Bill 119, a position based on many years of research by our scientists, including Dr Ferrence. At the conclusion of my remarks Dr Ferrence would like to add a few brief remarks of her own.

Being a public health organization the foundation is, of

course, applauding the measures contained in this bill. We think it is coming not a moment too soon because we have seen some disturbing trends recently among our young people.

You may recall some of the reports in the news media last November when we released the latest Ontario student drug use survey. The decline in drug use that we had been witnessing through the 1980s suddenly stopped; in fact the use of some drugs increased.

One of the most disturbing results in the survey came from the grade 7 students. Between 1991 and 1993, smoking among grade 7 students increased from 6% to more than 9%, a 50% increase. I would like to emphasize here that these students are smoking a product that is not only harmful to their health but highly addictive. The addictive agent in tobacco is nicotine, which has been described by the US Surgeon General as just as addicting as heroin and cocaine. While the Addiction Research Foundation does not like to compare different drugs in quite that manner, we have studied the difficulty in quitting smoking.

The ARF surveyed clients who had sought treatment at our facility for problems with alcohol, cocaine and heroin, among other drugs, and who had also tried to quit smoking: 57% of them said that cigarettes were harder to give up. That's harder than, for example, heroin or cocaine.

There is also a strong psychological component to the addiction. The head of our smoking clinic, Dr Rick Frecker, says that smokers have the same attachment to cigarettes as they would have to a friend. You might find that amusing, but when smokers quit, Dr Frecker says, they actually go through a period of mourning. If they have always had a cigarette with their coffee, they will now drink that coffee and feel the painful loss of a friend.

Young people can quickly become addicted to tobacco, but stopping is not so quick. Half of the smokers we asked in the Ontario student survey had tried unsuccessfully to quit smoking in the previous 12 months. Almost a third of those tried to quit three or more times. Almost half of those who tried to quit could not abstain from smoking for longer than one week and another 25% could abstain only from a week to a month.

We cannot, of course, expect totally to prevent young people from experimenting with cigarettes. After all, testing parental and societal limits is a simple and clear part of growing up. But we do think that Ontario should do all it can to prevent them from becoming addicted. There are two approaches which we can take to accomplishing this: Ontario should reduce young people's access to tobacco and we should reduce the appeal of tobacco.

Access is currently a big problem. The grade 7 students who are starting to smoke are minors, yet they have little difficulty in getting cigarettes. Bill 119 quite rightly proposes to restrict the sale of tobacco to persons 19 or older. Adolescents in fact consistently underestimate the addictiveness of tobacco. They are also being given a mixed message if they can start one legal addictive substance at 18, tobacco, and another substance at age 19,

alcohol. Their youthfulness leads to other health concerns. The US Surgeon General reports that the earlier in life you start to smoke the more likely you are to become a heavy smoker, have more difficulty in quitting and have greater risk of developing a smoking-related disease.

Adolescents will experiment with cigarettes before they reach the legal age, but the higher the legal age the longer we can prevent them from smoking regularly. We have seen this with alcohol. If you can delay a young person's regular use of alcohol, you may permanently reduce their drinking. Raising the age to 19 means that most high school students will not legally be able to get cigarettes. The new legal age will also mean that store owners will be able to demand to see a person's age of majority card as proof of identification when selling cigarettes.

Bill 119 also places restrictions on retail establishments, which the foundation supports. Research about alcohol indicates that if you broaden the distribution of alcohol, consumption will rise. In other words, if you make it easier to get, more people will drink, and if more people drink, more people will experience problems. The same holds true for tobacco. The flip side is that if you make the product harder to get, fewer people will consume it which, if you think about it, is just common sense. By restricting the outlets that can sell tobacco, Bill 119 will again make it more difficult for adolescents to smoke regularly.

There has been a lot of controversy over the proposed ban on the sale of tobacco in pharmacies. Cigarette manufacturers are blaming the government for this move, but let's remember that the proposal came originally from the pharmacists themselves.

In addition to reducing the ability of young people to buy cigarettes, taking tobacco out of pharmacies would have a great deal of symbolic value. It would remove another powerfully mixed message.

#### 1410

It would break the link between tobacco and a health care setting. Pharmacists would step squarely in line with other health care professionals in promoting good health, not selling a product that leads to disease and premature death.

It has been suggested that pharmacists who sell tobacco would be able to counsel customers to quit smoking. They should certainly do that, but I cannot accept the mixed messages in urging a customer to quit while with the other hand selling to them.

The Addiction Research Foundation applauds the Ontario College of Pharmacists for spearheading the move to end this conflict of interest.

Bill 119 also proposes the banning of vending machines that sell tobacco. Vending machines are very difficult to monitor, and teens who are not able to buy tobacco at retail stores would naturally turn to vending machines as their source. The foundation wholeheartedly supports a total ban on them.

Enforcement of these restrictions is, of course, key to the success of this legislation. It is no secret that current regulations are not enforced, enabling minors to get



cigarettes with ease. The foundation is greatly encouraged by provisions allowing the Minister of Health to appoint inspectors and by the fines stipulated by the bill. These should encourage greater compliance with the law.

As I mentioned a few moments ago, the other approach to preventing young people from taking up cigarettes is reducing their appeal. This is an area that may not be in the province's exclusive area of jurisdiction, but I would like the committee to recognize it and to consider it.

Tobacco advertising has been banned in Canada, although that is being challenged in court, but promotional efforts on the part of the tobacco manufacturers have not disappeared.

When you walk into a corner store you can still see forms of tobacco promotion at the point of purchase. Cigarette packages are prominently displayed at many store counters, for example. We should eliminate point-of-purchase promotions.

Even more disturbing, tobacco manufacturers are allowed to sponsor sporting and cultural events, and even to establish foundations that take on the names and graphic styles of various cigarette brands.

The February issue of *Flare*, a magazine aimed at young women, has a two-page advertising spread sponsored by *Matinée Ltd Fashion Foundation*. *Matinée* is, of course, a brand that is popular among young women. Believe me, this advertisement which I will show you is recognizably extremely similar to a *Matinée* cigarette pack. It surely is advertising.

That is the advertisement. That is a *Matinée* cigarette pack. I think recognizably, we are dealing with the same thing. It is, in my mind, absolutely tantamount to advertising in the same way as each morning I drive to work along the Gardiner Expressway and pass the most enormous pack of *du Maurier* cigarettes that you have ever seen, which is of course the *du Maurier* theatre.

By allowing this, we are letting cigarette manufacturers circumvent the advertising ban while maintaining the illusion that smoking is synonymous with glamour.

Although Bill 119 does not address this, I would like to add that the foundation strongly supports continued high taxes on tobacco. Indeed, one cannot talk meaningfully about tobacco laws and policies at the moment without considering the smuggling furore.

Much is being said about cigarette taxes and the burgeoning market in smuggling. Some critics liken it to the Prohibition era. They say that high taxes and smuggling are breeding a disrespect for the law that is eating away at the social fabric.

Thankfully, Ontario has stood firm on this issue, but other governments are wavering. We are very concerned with the reports that the federal cabinet is still seriously considering lowering cigarette taxes.

We support current tax levels on tobacco for a very simple reason. They reduce consumption. Research conducted in both Canada and the United States shows that adolescents are particularly sensitive to price. If cigarette prices are high, young people are less likely to start smoking or to increase their smoking. Conversely, if prices drop, young people, in disproportionate numbers,

will start to smoke. Nevertheless, high prices and high taxes do contribute to the smuggling problem, and we agree that it must be dealt with. But to do so by lowering taxes is absolutely the worst way. At best it would put a crimp on smuggling, but at the expense of declining tax revenues and of more people starting to smoke. If more people start smoking, then in the long run more will die prematurely; to reverse the old saying, a classic case of short-term gain for long-term pain.

But in reality, is it in fact even a short-term gain to reduce cigarette taxes? Let us ask ourselves for a moment who would benefit from a tax, and therefore a price, reduction? Would smokers gain? Well, we know that 75% of all smokers want to quit and that high prices are the best way of reducing smoking. Indeed, the foundation's surveys tell us that even before smuggling became a major issue, 40% of smokers themselves, and that's a minority of the population at large, wanted to maintain or increase taxes.

Would it be retailers who benefit? Maybe, but provided we deal with smuggling, the proportion of about a quarter of the cigarette market that has been lost to smuggling should come back to them anyway. I can see no reason why we should put them in a better position than they were before all this furore started.

What about manufacturers? Well, what about them? They have already made enormous windfall gains from this situation. They have been able to pump up their profits under the cover of high taxes. Beyond that, they have shamelessly manipulated the situation to their great advantage. Why on earth would we cave in to their equivocations and their obfuscations? Why would we let these profiteering puppeteers continue to pull our strings on this issue?

The fact is that it took us several years to get into this mess and there isn't a quick fix. Lowering taxes makes no sense at all. Through taxes, we have made big gains in the past decade in reducing smoking and thereby saving lives. In fact Canadian taxes are not high by the standards of developed countries, whereas US taxes are absurdly low. We must deal with smuggling not by lowering taxes but by encouraging US federal and state governments to increase their taxes, as they intend, to finance the Clinton health care plan.

We also must reimpose the highly effective Canadian federal export tax, which drove the cigarette manufacturers to such a frenzy of lobbying that it was mysteriously withdrawn shortly after it was introduced, and we must increase enforcement efforts. The problem of smuggling will not be solved overnight or by a single measure, but it can be solved.

These comments have already extended well beyond the purpose and intent of Bill 119 itself and indeed to matters partly beyond provincial jurisdiction. But Bill 119 will be of little significance if it is not seen in a broader context and if other appropriate steps are not taken by intergovernmental relationship or by other means available.

In summary, reduced access, as proposed in Bill 119, and continued taxation at current levels is undeniably the most potent combination of measures we as a society can



undertake to reduce smoking among our young people. If these measures are implemented, the new generation will thank us in years to come.

I'd like to thank you for your attention. I'd be happy to answer any questions you may have, but first I'll ask my colleague Dr Roberta Ferrence to give you a few brief comments of her own.

**Dr Roberta Ferrence:** Thank you, Mark. Good afternoon. I am a senior scientist with the Addiction Research Foundation and also the director of the Ontario tobacco research unit. I've been involved in tobacco research for more than 10 years and in addiction research for more than 20 years.

I could give you some horrifying information about the health damage caused by smoking in Ontario. I could offer you depressing statistics about mortality from smoking-related illnesses that will happen in the future. As important as these are, and I think you've heard some of them from other speakers, I'm not going to do that today.

On a more personal level, I could tell you about my grandmother, one of the first of the new women who began smoking in the 1920s. She died of pneumonia at age 35, leaving six children. I could tell you about her husband, my grandfather, who helped her to become a smoker. He died at age 52 of coronary heart disease. I never knew these grandparents.

1420

I could tell you about their children: My uncle, a heavy smoker, who died at age 52 of an aortic aneurysm, which is a cause of death that is four times higher in smokers; or his sister, my aunt, who recently died at age 70 of oral cancer brought on by tobacco and alcohol use; or about my own parents. My mother, the child of two smoking parents, started lighting up at age 13. She finally quit in her late 60s when a heart condition was diagnosed and, fortunately, she's still with us. My father smoked a pipe for 50 years and finally quit after he had a heart attack.

I could tell you about my own experience, about starting to smoke at age 17 because I wanted to find out how my mother felt when she had to have a cigarette. I was doing early research on addiction, I guess. I started as a half-pack-a-day smoker.

I don't think that my family is unusual, but this is all in the past and what I really want to tell you about is the future. What I want to tell you about is my son.

I'm a parent, like many of you. My oldest son is 18 and he has been smoking for seven years. He was able to begin his addiction buying cigarettes at the corner store at the age of 11. I have not smoked for 25 years. My children know about the hazards of smoking. My home is smoke-free. My children were exposed to health education in the classroom, and for this child it didn't help.

My son is my litmus test for what works. He has no problem with educational programs or media campaigns; he just ignores them. What he can't ignore and what upsets him most and what he confronts me with are tax increases and effective restrictions on sales to minors. Unfortunately, it's too late for the proposed legislation to

greatly affect my son; he turns 19 this year. At age 35, if he hasn't quit, he will have smoked for 25 years and will be at risk of serious health problems at that early an age.

For all the children who are now aged 10, 12, 16 or even 18 who are starting to smoke, this legislation is critical. Delaying the onset of regular smoking by six or seven years will make a huge difference. They may in fact never become addicted smokers.

The legislation is important, but we have had legislation on the books for almost 100 years. It must be enforced. Enforcement is critical and it can be done. Some US communities have reduced sales to minors, in compliance with the Synar amendment, to 20%. We can do the same; we can do better.

**The Chair:** Thank you very much, and we'll move right to questions. Mr Arnott.

**Mr Ted Arnott (Wellington):** Thank you very much for your presentation. It was excellent. I agree with almost everything in here. There's one thing I would like to ask you about, though, and that is your suggestion that the tobacco taxes in the United States be increased.

Every Democratic president, to my recollection, since Harry Truman has promised the people of the United States universal health care. I'm not holding my breath for Bill Clinton. I hope he's successful, but I wouldn't be surprised if he's unsuccessful. There's also the matter of state governments to consider and there's also the matter of Congress to consider. He doesn't have as much direct control over his own legislative agenda as our Prime Minister and Premier.

Do you really think it's realistic in the short to medium term that taxes in the United States will rise such that our problem with respect to smuggling will diminish?

**Dr Ferrence:** I think it's a likely but not a sure outcome. We do have the option also of lobbying neighbouring states, and if we do both kinds of efforts we're more likely to be successful in at least one area.

Getting the United States to raise their prices is only part of the package. The other options that we've talked about, and others have talked about, such as the export tax or restricting exports and package changes and a number of other things, are all part of a package and it could be done without cooperation from the US. But I'm optimistic that there will be significant changes there.

**Mr Arnott:** Another question that we discussed yesterday and we've been sort of tossing it around: If you're under 19 right now, it's an offence and you can be charged and fined for consuming alcohol. The actual person who's consuming it can be charged. Do you think it would be a disincentive to young people if it were illegal for the actual consumption, for actually lighting up a cigarette, smoking a cigarette and being in possession of a cigarette? Do you think that would help at all?

**Dr Ferrence:** The federal legislation applies to possession as well as purchase, and it has been in effect since 1908 and hasn't been enforced.

**Mr Arnott:** Very nominal—

**Dr Ferrence:** My personal feeling is that you don't attack the victim. Kids are not to blame for lighting up at

the age of 12. We have to go after the suppliers. We have to structure society so that it's not possible for kids to smoke.

**Mr Arnott:** I just think that a kid at age 18 carries some degree of responsibility for his own actions. In a situation where we're saying that the vendor who sells tobacco to—assuming this bill passes—an 18-year-old adult really, and the vendor has to carry 100% of the responsibility and all the repercussions and the 18-year-old walks out of the store, puffing and smiling, it just doesn't seem right to me.

**Dr Ferrence:** But we have similar attitudes towards the sale of alcohol. Increasingly people are charging the server rather than the individual who gets drunk. I think people who sell products in a society have more responsibility than the individual, because they have more privileges, they have a licence to make money from this product, and I think with those privileges come responsibilities. The problems of enforcement on an individual level are enormous. It is much easier to enforce when you have outlets rather than individuals. I think it's also a lot more palatable to most people.

**Mrs Haslam:** I'd like to take a look at a couple of your concepts. You talk about alcohol. Obviously the Addiction Research Foundation has done a lot of work in this area, and in tobacco. You talk about broadening the distribution, therefore consumption will rise, and you talk about if you make the product harder to get, fewer people will consume it. By restricting the outlets that sell tobacco, Bill 119 will again make it more difficult for adolescents to smoke regularly. I would like to think you mean adolescents and adults to smoke regularly.

But it's been brought up to us that by taking it out of one place—and I'm not saying aye or nay; I'm just saying it's been brought to our attention that if you take it out of the one place that doesn't want to see it go out of their stores, the consumption won't go down, because they aren't the ones selling to the adolescents under age. They're the ones who are actually controlling it better. I'm wondering if you could elaborate a little on this around the distribution and the accessibility, whether it's to adolescents or adults, whether your research does really talk to that issue.

**Dr Ferrence:** There is a fairly large literature on outlets in the alcohol area. It is true when you have saturation, when you have an outlet for tobacco on every corner, that removing a quarter of the outlets isn't going to make an enormous difference. It will probably make some difference, but you're not going to cut consumption in half just from that one measure.

I think its main importance is—I hate to use the word “symbolic”; it's more than that. It's getting it out of the health care system. It's only Canada and the US in the world that sell tobacco in pharmacies. Most people would find this absolutely bizarre.

Certainly in a small community, what they found is when there are only a few outlets, removing some outlets can make a substantial difference. I think we have to see this as part of removing it, and this is the way the bill was intended from the health care area rather than from the retail area. I think there's an important difference

there. As Mr Taylor mentioned, there's an additional matter that pharmacists charge a rather hefty fee for dispensing drugs. When they do this, some of them, especially in small pharmacies, do counsel patients. When a pharmacist is prescribing a nicotine replacement product or prescribing, say, something to someone who has bronchitis or some other smoking-related illness, this is an opportunity for the pharmacist to engage in some counselling and some prevention or secondary intervention work.

1430

If they are selling tobacco, I think they're less likely to do this. They have a serious conflict of interest, and that I think is another key reason. It's just like if you eliminate advertising from publications, all of a sudden you find it's much easier to get in an article on the health effects of smoking. It's the same sort of thought, and I think that's a critical point as well.

The main purpose of the measure is not to reduce consumption, but if we go on to eliminate other sources in the future, we will have an even more sizeable effect on consumption.

**Mrs Haslam:** That was an interesting point. Light-bulbs went off in my head when you talked about putting an article in when some of your advertising dollars are being given by a tobacco manufacturer. That's a very good point. I totally missed that in my thinking about this.

You talked about enforcement—you don't attack the victims—and that in some places, through effective enforcement, the results of adolescents smoking have been reduced to 20%, and you say that we can do better. Your bottom line was that we can do better. I wondered if you had suggestions on how you could do better on the enforcement.

My concern is that we're talking about taking them out of an area where pharmacists are when it isn't the pharmacists selling it, it's the clerks at the front of the store, and then better enforcement in any of those stores, in convenience stores or all, is necessary. But how would you get it to 20%?

**Dr Ferrence:** It has been reduced to 20% in some US states by sting operations with regular enforcement, not particularly high fines, but it's the frequency of checking out, are kids being sold to? Throughout the United States I think licensing is the rule. It is easier when you do have licensing to keep track of what's going on and there is more of a penalty there, but it can be done by other means.

**Mr McGuinty:** Thank you very much, both of you, for your presentation. I want to take the opportunity as well to compliment you for the work that you do. It proved to be of invaluable assistance to me in putting together my private member's bill. I think I may even have spoken with you in that regard, Dr Ferrence. I'm sure the government found your statistics very helpful as well.

I wanted to ask you about this recent increase in tobacco usage we're seeing with young people. Do you know the contributing factors behind that?



**Dr Ferrence:** We have seen a small increase among grade 7 students in our latest student survey. It's difficult to tell. It would be more helpful to have another year of data to see if this is a trend. But it's concerning.

I think quite seriously that the major part of the problem is that we haven't made major gains in enforcement at the local level. In the US, with their much lower prices but higher levels of enforcement in many states, they are actually starting to see increases now among adolescents. But their prices are so much lower that it's not difficult to understand.

**Mr Taylor:** If I may, I'd just like to add to that answer. As a non-scientist, I'm always entitled to be a little more speculative than my scientific colleagues.

I think, with the wisdom of hindsight, it is not unreasonable to speculate that the increase in smoking among grade 7s, which is something we observed last year, in the middle of last year, roughly speaking, may at least be associated with the pretty ready availability of cheap smuggled cigarettes. I can't prove that, but it doesn't seem unreasonable to speculate in that direction.

Also, though, and more disconcertingly in my mind, it is associated with an increased attitude, or a decreased attitude, if you like, of the willingness to cooperate and to depend on colleagues, siblings, school mates and so on. There is a process taking place in school children's attitudes, or students' attitudes, that seems to be withdrawing from that sense of connectedness. Again, I am extrapolating way beyond anything the data justify. I'm just applying my own judgement to it.

I don't see that being inconsistent with the attitudes that surround smuggling and the sense that: "Oh, well, everybody's doing their own thing, they're doing it for their own advantage. Why shouldn't I?" I think there is a syndrome of me firstism which the smuggling issue is simply a beautiful visible example of.

**The Chair:** Thank you very much. I'm sure we could profitably spend more time and I regret that just with the number of witnesses we have to conclude at that point. Again, thank you for coming before the committee.

#### MEDIS HEALTH AND PHARMACEUTICAL SERVICES

**The Chair:** If I could then call on the representatives from the Medis Health and Pharmaceutical Services organization. Could I just remind members that we're in a new phase here. I will be rotating and beginning with Mr Arnott, and then if we have time for more, but we may only have time for one question per witness. I'd appreciate your help and assistance because it will be difficult.

Welcome to the committee, and if you would be good enough to introduce yourself, we have a copy of your brief and please go ahead.

**Mr Frank Goodman:** My name is Frank Goodman and I am regional vice-president of Medis Health and Pharmaceutical Services. Mr Chairman, ladies and gentlemen, thank you for the opportunity to present my views and to represent my organization to your committee during your deliberations on Bill 119.

I represent Medis Health and Pharmaceutical Services Inc, which is a wholly owned subsidiary of McKesson, a

public company. I'm responsible primarily for the operations of Medis in the province of Ontario. Medis is primarily a pharmaceutical distributor. Our mission statement is, "Medis is Canada's leading distributor to pharmacies, fulfilling customer needs by offering superior service at a competitive price and the most efficient distribution system in the health care industry."

Medis employs over 1,200 people in Canada and has 12 distribution centres located from Vancouver, British Columbia, to St John's, Newfoundland. In Ontario, Medis employs over 300 people with distribution centres in both Toronto and Ottawa. We stock over 3,500 different pharmaceutical products alone. Every day we fill about 30,000 order lines which are shipped to over 1,100 pharmacies in Ontario, mostly via our own fleet of 36 trucks. Our investment in product inventory exceeds \$40 million.

Virtually all our customers are pharmacies and include independent drugstores, hospital pharmacies and chain drugstores in every geographical area of the province. We supply a full range of pharmaceutical products, as well as non-prescription drugs, health and beauty care items, confectionery and tobacco. We even stock pharmacists' supplies, such as vials, bags and labels. We are virtually a one-stop shop for our client pharmacies.

At the outset of my discussion, I want to make it very clear that we support the fundamental intent and the principles of Bill 119. There is considerable evidence to support the fact that tobacco is a harmful product, and it is in the best interests of society to reduce tobacco consumption, particularly by young people. However, we are seriously concerned with the implications of selectively forcing the removal of tobacco from any given retail format, in this case drugstores.

Tobacco is a legal commodity. As such, it is reprehensible to discriminate against or for any particular class of trade to the advantage of others. We do not see how the removal of tobacco from drugstores will further the objectives of Bill 119, of the government or of society. It is unlikely that people will stop smoking because they can't purchase their cigarettes in drugstores. There are just too many other sources of supply.

I'm sure this committee has heard and will hear more from representatives of the drugstore industry how drugstores are more responsible than most tobacco outlets relating to sale to minors, and you've also heard of the direct financial impact on drugstores of the removal. I'm sure you've also heard how the removal of tobacco from drugstores will fuel the underground economy, which is not at all particular about selling to minors and which is destroying the tax base in our society and encouraging organized crime. All of these will directly force drugstores to close, to reduce staff or to reduce opening hours and ultimately to reduce health care service.

I'd like to demonstrate to you yet another impact of the removal of tobacco from drugstores that relates directly to my industry, and that will translate to a health care cost and a health care quality issue for our province.

Medis's core business is the distribution of pharmaceuticals. We provide an essential service within the health care industry by ensuring that every drug is



economically available in every hospital and every community pharmacy in every community without delay.

1440

The Ontario drug industry consists of several hundred manufacturers, large and small, over 2,200 retail pharmacies, many of them small dispensaries in rural communities, and over 200 hospital pharmacies, many of them also in remote communities across this vast province.

It's impossible for every pharmacy to stock every drug at all times. Distributors such as Medis make it possible for any pharmacy to purchase any drug in quantities as small as a single bottle and to get delivery of that drug either the same day or the very next day in virtually any part of Ontario, however remote.

Other product categories are serviced by Medis as a convenience to our customers to enable them to manage their businesses as efficiently as possible. Tobacco is such a category. It is handled by distributors at minimal incremental cost.

I'd like to illustrate this. When a retailer places an order from Medis, we must take the order electronically, verify the credit rating of the retailer. Our warehouse order fillers pick the order and pack the order, and our trucks deliver the order. Then we collect our bill, and the cycle is complete. We have a large investment in physical facilities, inventory, computers and materials handling technology.

Every one of the activities that I mentioned must take place for every order, regardless of whether that order is for a single bottle of pills or a large number of drugs or whether the order also contains shampoo, candy bars or cigarettes. Therefore, the additional cost to handle the cigarette business is quite small. So the profit we make on this transaction helps us to offset the cost of delivering drugs in small quantities every day to the most remote community. In fact, the drug distribution industry is a major contributor to the efficient operation of the health care system, since our net service charge is in the low single-digit range. By the way, Ontario drug distributors have by far the lowest service charges in Canada, competitive with the largest markets in the USA.

One of the principles espoused by the Ministry of Health is universal access to health care throughout the province. In support of this principle, Medis charges the same prices for its drug distribution service regardless of the location or the size of the retail store or of the size of the order.

If tobacco products are removed from drugstores by Bill 119, then Medis will have reduced profit opportunities. This will force us to raise our prices for pharmaceuticals, which will increase the cost of health care to all Ontarians and to the Ministry of Health through the Ontario drug benefit plan, which pays for about 40% of prescription drugs in the province.

Alternatively, Medis will have to reduce staff and inventory to reduce expenses. This will substantially reduce our ability to provide the service to our customers that they need in order to provide rapid access to all drugs to all patients. We may have to cut deliveries to

twice a week or have more out-of-stock situations.

Can you imagine a scenario—and I'll address this personally to the members of the committee—where your vacationing eight-year-old son has a severe, acute infection and the local, rural drugstore doesn't have the prescribed product in stock? Even worse, the pharmacist then tells you that his distributor has reduced service and the next truck won't arrive for three days. None of us would consider that's acceptable, but that is the kind of option facing our industry if tobacco is removed from pharmacies. Our investors will force management to cut costs and curtail service in order to maintain profits. That's the real world.

We sincerely hope that you'll take a hard look at the pharmacy provisions of Bill 119 and that you'll agree with us that they serve no purpose and they could damage an essential element of health care, which is fast and efficient availability of any drug, anywhere in the province, at any time.

Thanks for your attention, and I'll be happy to answer any questions that you may have.

**Mr Arnott:** Thank you very much for your presentation. Yesterday, the Non-Smokers' Rights Association made a presentation here and the name of your company came up. There was a handout that was released—

**Mr Goodman:** I'm impressed.

**Mr Arnott:** Are you aware of this?

**Mr Goodman:** Yes, I am.

**Mr Arnott:** Okay. It appears to be a promotion that has been sent by your company to pharmaceutical buyers, and it says:

"We've lowered our upcharge on hundreds of high-velocity pharmaceutical products. Compare our prices and save. Further, all purchases, including drop shipments, contribute to your volume rebate plateau. Just a few extra cases of tobacco per week can double your volume rebate on all pharmaceuticals. Contact your Medis sales representative for details."

It appears to be encouraging the pharmacists to sell as much tobacco as possible, such that they'll have a reduction in the cost of their pharmaceuticals. Now, is that presently the policy of your company, to encourage that sort of thing?

**Mr Goodman:** I'd like to make several points related to that. Firstly, I was aware that the issue was raised here. The particular flyer was distributed in January 1990. It was publicized to the Queen's Park media by Mr Mahood's group in May 1993, so I would assume that it just came to his attention at that point in time.

The particular program that it discussed is not currently the program, but it is fair to say that a customer who concentrates his business with our organization, buys everything that he can through our organization, will be a more profitable customer for us and we share that profitability back to him by way of discounts.

At the moment, through Bills 54 and 55, we're not able to give rebates on pharmaceuticals to bring it below BAP, but we do have a rebate program on pharmaceuticals which are sold above BAP, and a pharmacist who

buys a high quantity of product in total from us can get a higher discount than others. That discount is applied to his pharmaceutical products, and I would make the point that this simply supports the main premise of my discussion, which is that tobacco business adds to our profitability and allows us to distribute pharmaceuticals at lower cost.

**The Chair:** Mr Goodman, could you just tell us: BAP?

**Mr Goodman:** I'm sorry. Best available price.

**Mr Arnott:** That's a problem, because it indicates that the pharmacist may have a direct incentive to try to maximize his or her sales of cigarettes.

**Mr Goodman:** Well, I would suggest to you that there's nothing that we sell to the pharmacist that he can't buy from 100 other sources. We're simply encouraging him to purchase his tobacco from us and not from competitors who may or may not sell pharmaceutical products.

**Mr Arnott:** Pharmacists' groups are opposed to this provision in the bill, in that they're the only ones who can sell tobacco responsibly, yet it appears the potential is there for a direct interest in trying to push tobacco as fast as you can.

**Mr Goodman:** I would suggest to you that the additional profit generated by a pharmacist from buying his tobacco from us as opposed to any one of a number of other wholesalers, who may not be pharmaceutical wholesalers, that additional profit would be trivial in comparison to the total sales of his tobacco volume. It's a very small number and would certainly not give him incentive to behave any differently than he otherwise would.

**The Chair:** Mr Wessenger, you have one minute.

**Mr Paul Wessenger (Simcoe Centre):** Okay. That's going to be very quick then. First of all, I'd just like to ask you, do you personally feel that cigarette smoking is adverse to health, and do you think we ought to encourage it in our society?

**Mr Goodman:** I did point out in my brief that we do support the fundamental intent of Bill 119.

**Mr Wessenger:** This is the whole point about health professionals: Health professionals are supposed to promote health. Don't you see a problem with health professionals being seen to promote something that is not healthy? Doctors smoking would be against promoting good health, pharmacists handing out a poison is against good health. Medis Health and Pharmaceutical Services Inc selling tobacco is a conflict of interest in the impression you're creating. It would be interesting to know, for instance, how much is tobacco out of your total sales.

**The Chair:** Question, please.

**Mr Wessenger:** That's what I've got. How many?

**Mr Goodman:** I think there were three questions in there.

**Mrs Haslam:** We try to do that.

**Mr Goodman:** I don't think that it's my part to comment on the ethical issues associated with selling tobacco in drugstores. I'm here as a businessman and I'm

here to tell you the impact the proposed legislation will have on my business directly and then indirectly on the health of Ontarians. I don't think it's my position to comment on the ethics of the matter.

**The Chair:** Thank you very much for coming before the committee and for your presentation.

1450

#### METROPOLITAN TORONTO PHARMACISTS ASSOCIATION

**Mr Samuel Hirsch:** My name is Samuel Hirsch and I am the past president of the Metropolitan Toronto Pharmacists Association. I'm joined here by Ruth Mallon, current president of the MTPA. We are here to speak on behalf of the Metropolitan Toronto Pharmacists Association's written submission to the ministry in respect of Bill 119.

What you've received is our actual submission. What we're going to talk on today is just to summarize some key points of it. In that case, we'll try to be brief and not inconvenience the time we have here, and hopefully have some questions afterwards.

**The Chair:** Thank you for the fuller brief as well.

**Mr Hirsch:** That's quite all right.

When I say we represent the Metro Toronto Pharmacists Association, I'm referring to the more than 200 pharmacist members who have shown their support for our submission. The members who operate in or are employed by community pharmacies are particularly concerned because they believe they are being regarded as part of the problem when indeed they see themselves as part of the solution.

Community pharmacies in Metro Toronto and a large percentage of the 1,500 pharmacies in Ontario are often the first-line professionals in the consumer health chain, coming face to face with patients who have a medical or health concern. These patients, who in some cases have limited access to their physicians, look to the pharmacist for information, for education and medication counselling.

For example, the patient may ask the pharmacist: "What's good for this cough? I can't seem to shake it." The pharmacist may ask the patient if he or she is a smoker, and this information can be used to counsel a patient regarding smoking and health and cessation. By contrast, the same person who purchases cigarettes at convenience stores, mass merchandisers or gasolene bars will never be exposed to anti-smoking counselling.

Pharmacies are not part of the problem; we are part of the solution. We believe that sections of Bill 119 are entirely valid and we are prepared to support them; for example, the minimum legal age, vending machines and of course penalties for selling to minors.

While on the topic of minors, I find the supposition that selling tobacco in the front shop of a pharmacy gives minors the impression that pharmacists approve of smoking to be a little strained. What of the thousands of other legal products we sell? What aura of approval do pharmacists give to disposable diapers, condoms, hair preparations? In fact pharmacists who are responsible for handling narcotics and other controlled substances give



out a much stronger message about tobacco use when they refuse to sell to minors; and, yes, we do refuse to sell tobacco to minors. We are very, very strong in that respect.

As you are well aware, removing tobacco from about 1,500 pharmacies in Ontario, leaving almost 30,000 other vendors to pick up the slack, is merely reshuffling the market so that 30,000 retailers experience increased sales and 1,500 are left struggling to recover from the blow. What makes it worse is that many of these 30,000 other vendors are our neighbours, in the same shopping centre, strip mall, next door or perhaps down the street. This is a trade barrier and this is within the borders of our own province.

I'll give you an example: Down the street from my pharmacy is a small bakery selling nice breads and pastries. When the owner of this particular shop first heard of the pharmacy provision in Bill 119, not knowing how the system worked, that you needed three readings and hearings, his immediate reaction was to start selling tobacco in anticipation of my being taken out of the market. The same is true for my small greengrocer right beside me. Without being enacted, Bill 119 has already succeeded in increasing the availability of tobacco, and this with no new jobs being created.

We are distressed, as you might also be, by the magnitude of illegal smuggling of cigarettes, which is increasing daily. It robs the province of much-needed tax revenue. We submit that if the inevitable happens and 1,500 legal retail outlets are removed from the geography of Ontario, thereby making access less convenient for smokers, more and more of them will turn to the underground market system. The result? Less and less tax revenue for the province and no decrease in smoking.

The MTPA is not alone in protesting the proposed removal of pharmacies from the retail tobacco trade. I'm sure you've heard many points made over and over again, namely, you won't influence people's decisions about smoking, you won't reduce consumption by one single cigarette, you won't stop new retailers from filling the need in the market created by the forced exit of pharmacies, you won't keep supermarkets, convenience stores and gas stations from expanding their tobacco business. In short, you will not achieve the government's health strategies in this point.

What will happen? What will we achieve? You will inflict financial damage on community pharmacies. You will force the closure of some pharmacies that are already reeling from intense competition and overall decreased consumer spending. You will create additional hardship in the community at large because of closed pharmacies. For example, our seniors will lose access to the long-standing relationship, in some cases, with their local community pharmacist. In certain cases, the elderly will have to travel further afield to have their health needs met. Pharmacies that manage to survive will do so by downsizing. This means some permanent loss of jobs. Pharmacies will not have the sales and customer base to warrant such customer services as we now give: extended hours, delivery of emergency prescriptions.

History shows that even those who have favoured the

removal of tobacco products for sale in pharmacies have not won their points. The example in Quebec, a recommendation by l'Ordre des pharmaciens du Québec, was considered by the Quebec health ministry and subsequently by a cabinet committee and its legal counsel. The bill in question was never implemented because the government recognized both the economic viability of pharmacies and legal ramifications from possible court challenges.

Pharmacists are united on their democratic right to choose what products they put on their shelves to ensure the profitability and viability of their businesses. We really don't want to be told what legal products can or cannot be sold. Many pharmacy organizations throughout the country, including MTPA and the OPA, Ontario Pharmacists' Association, advocate that governments should allow pharmacists to decide for themselves whether or not they sell tobacco.

As you know, we are already a very highly regulated profession. We accept rules and regulations when the purpose makes sense. We cannot accept anything as senseless as the pharmacy restrictions proposed by Bill 119, whose purpose seems to be nothing more than the government's attempt to position its resolve as politically correct, symbolic and idealistic.

In our written submission, which I mentioned previously, we proposed an additional strategy that can contribute to reduced tobacco consumption, a strategy that can uniquely be implemented by the community pharmacist. Of all retail tobacco outlets, the drugstore is the only one that provides education about smoking cessation programs and nicotine replacement therapies. As demonstrated in my earlier example, the staffs of all other tobacco outlets are not equipped to counsel a patient about the hazards of tobacco use.

With respect, we suggest that government should be using our services to help alleviate the situation. Please don't exclude us. Don't restrict our business. Don't put some of us out of business altogether. We are not part of the problem; we are part of the solution.

Now I'd like to introduce Ruth Mallon, who will carry on with her presentation.

**Ms Ruth Mallon:** Picking up from my colleague's last point, we don't believe that your strategy, as proposed in Bill 119, will have any positive impact on at least two elements of your strategy, namely, protection from exposure to environmental tobacco smoke and encouragement of smoking cessation, nor do we believe that a strategy based on social acceptance will have any appreciable effect.

**1500**

Our contention is reinforced by the chief medical officer of health, "Voluntary long-term avoidance of smoking can be extremely difficult for those who have become addicted to nicotine, even when they are strongly motivated to stop." We think tobacco use is too important an issue to be left strictly in the realm of social engineering and symbolic gestures, especially given the recent data revealing increased rates of smoking.

As it is now, especially in Metro Toronto, the ban on



smoking in commercial and public buildings has forced addicted smokers outdoors, even in subzero weather. They are made to feel substandard and second-class citizens. They are becoming alienated from our society, yet they continue to smoke, not because they haven't heard the health warnings, but because they just can't. They need our help, not our derision.

We agree with the medical officer of health that we must take thorough and relentless action to help smokers to quit. Your strategy of duplicate warnings on packaging and a campaign is probably not what the medical officer of health had in mind when he said "relentless action." Thirty years of messages have not worked. That's why we're here today. More messages alone may be an escalating commitment to a losing course of action.

A ban on tobacco sales in pharmacies would send a message to smokers, but not the one you anticipate. Consumers will interpret this message as, "Buy your tobacco products elsewhere," and they will. I do not see anything in this bill that prevents anyone in this room from opening up new businesses selling tobacco. Your strategy lacks one important component, one in which pharmacists can play a critical role, a professional face-to-face voice of authority to children and adults about tobacco use and about the availability of smoking cessation programs and nicotine replacement therapies.

Throughout Ontario, teachers are bringing groups of youngsters to the pharmacy to learn about good drugs and bad drugs. Throughout Ontario, pharmacists are conducting community seminars on drug use and abuse. We are a prime communication vehicle to reinforce the government's message.

Our proposed alternative to the ban relies on this economic truth. While the demand for tobacco is inelastic in the short run, the demand for a cessation drug, a therapy, is elastic. In effect, you can increase the demand for all forms of cessation therapy by lowering its cost to the consumer. Because the nicotine in tobacco and nicotine drug therapies can be considered interchangeable products with no other substitutes, any increase in the demand for one results in a decrease in the demand for the other. An elegant balance exists. We propose too that the government tackle secondhand smoke issues on an environmental front, much as it did with the tire tax program that was set up for the purpose of finding means to reduce the environmental impact of that particular waste.

We submit that more creative research is needed before the decision is made to put the axe to the retail drug industry in Ontario, research that finds ways to truly help addicted smokers who are role models, truly influence the developing habits of children and truly addresses reduces the environmental impact of tobacco use.

In conclusion, we hope you will consider our suggested alternatives in which we have a role to play. We are not part of the problem. We want to be part of the solution. We hope you recognize that our suggested alternatives are based on an understanding of drug addiction and the realization that our patients need our services. We are not part of the problem. We are part of the solution. Please don't throw the baby out with the bathwater.

**The Chair:** Thanks very much, and again thank you for the longer presentation which you've given to us and which we can read. I'm going to try to get in two questioners here, Miss Haslam and Mr McGuinty.

**Mrs Haslam:** On the front of your thing here, it says that your membership works in chain drugstores. I wondered if one of those chain drugstores was Shoppers Drug Mart?

**Ms Mallon:** Some of our members are indeed Shoppers Drug Mart pharmacists.

**Mrs Haslam:** Mr Hirsch, are you a pharmacist and what is the name of your drugstore?

**Mr Hirsch:** I franchise a Shoppers Drug Mart in Toronto.

**Mrs Haslam:** Well, you're in luck, because I heard this morning that Imasco, your parent company, has just posted fourth-quarter net earnings that rose 13% to \$125 million. That is a tobacco company that has made, in one quarter, \$125 million in profit. So if you're a Shoppers Drug Mart—

**Mr Jim Wilson:** Make them illegal then.

**Mrs Haslam:** I said he was lucky, Mr Wilson. I said he was lucky.

*Interjections.*

**Mr Hirsch:** If I may, Ms Haslam—

**The Chair:** Order, please.

*Interjections.*

**Mrs Haslam:** I wanted to understand—

**The Chair:** Order, please. Miss Haslam. Look, there are times when we have questions or where there will be differences of opinion, but if we could have the question as direct as possible and then permit the witness to respond, I would appreciate the cooperation of committee members.

**Mrs Haslam:** I understand. I don't yell at Mr Wilson when he goes on his trips.

I understand that Shoppers Drug Mart in some medical clinics do not sell tobacco. I understand also that there are few Shoppers Drug Marts that are dispensers only. I wondered, though, do all Shoppers Drug Marts have the total freedom of choice to decide if they sell tobacco?

**Mr Hirsch:** First of all, I'd like to comment on what you mention about Imasco posting results. Imasco consists actually of five units.

**Mrs Haslam:** Yes, I'm well aware of that.

**Mr Hirsch:** So the tobacco unit is just one piece of the entirety of the company.

**Mrs Haslam:** So is Shoppers Drug Mart.

**Mr Hirsch:** That's correct and there are other pieces as well so we have profitability in one section and not so much in the other.

**Mrs Haslam:** I spoke with one of the gentlemen in your company and he said that even though there's a 20% decrease in tobacco sales, it's still a profitable item, so I'm well aware that you are one of five groups in Imasco.

**Mr Hirsch:** That's correct. On your second question,

whether or not our freedom to sell tobacco—as we said before, the product itself is a legal product. Also, its economic viability sustains our business and there is no reason, while it is a legal product, for us not to sell it.

**Mrs Haslam:** Do you have a choice?

**Mr Hirsch:** We have a choice of what we sell, in most cases, but we prefer at this point to sell tobacco. That's been the thesis—

**Mrs Haslam:** But as an independent owner of a Shoppers Drug Mart, do you have the choice and is it your decision if you will sell tobacco?

**Mr Hirsch:** I would be foolhardy not to sell a legal product.

**Mrs Haslam:** Do you have the choice?

**Mr Hirsch:** It's not a question of choice; I'd want to. Just like I have the choice to sell toothpaste, like I have the choice to sell diapers, like I have the choice of anything else, it would be foolhardy for me not to sell a viable product.

**Mrs Haslam:** So you could actually say no to tobacco, is what I'm trying to find out.

**Mr Hirsch:** It's not a question of saying no; it's a question of being in business.

*Interjections.*

**The Chair:** Order, please. The question's been asked and the gentleman has responded.

**Mr McGuinty:** Thank you for your presentation. This is a controversial issue, as you will have gathered, no doubt.

To me, there's really only one issue here at the end of the day. I'll be very frank with you, I find it difficult to accept that pharmacists can both sell tobacco products and counsel against the use of tobacco products at the same time. I don't feel we should really give a lot of weight to the argument that pharmacists are more responsible in terms of how they sell tobacco products.

The important issue here for me is we have to weigh the gain purportedly to be achieved by banning the sale of tobacco in a pharmacy against the economic loss that will be sustained. I've got some numbers on the losses. I've got a Coopers and Lybrand report. We had Pharma Plus people in here talking about some numbers. The presenter before you gave us an idea of some of the downsides.

My concern is, I need some numbers to attach to this symbolic side. Maybe you can help me in this regard. Have any surveys ever been done on your customers as to why they go in? How many are going in for prescriptions and how many are going in for other items?

**Mr Hirsch:** We know the majority of them come in for regular drug items. We know there is a small percentage who do come in for the tobacco products. It's a simple process to find out exactly where they're headed for when they come into a pharmacy. In many cases, they're just coming in there on impulse.

As far as getting hard numbers, I find it difficult, especially people who have been coming to this committee and making all sorts of predictions on what's going to happen, when our governments, our federal government,

our provincial government, can't even predict the deficit.

There's no way of knowing hard numbers when you're losing jobs, when we're going to take out a product. One thing we do know, and we have proof of it, is that some of the stores will close. Some have already closed and this is going to be the inevitable outcome. We can't look into our crystal ball right now and say exactly what's going to happen, but we are dealing with an economic truism.

On the other hand, we still feel that education is the big thing. We have heard over the days that once people are 20 years old, they're committed smokers. We propose that we'd like to get them when they're younger, when they're children. We want to go into the public schools. We feel we should be going after them at age 7, 8 and 9. When we walked in here Ruth and I saw nine children sitting on the stairs, five of whom were smoking. This was about one hour ago. So we have a problem out there. Pharmacists want to be part of it but we need our economic viability.

1510

**Ms Mallon:** Don't misunderstand us. We think tobacco is a horrible thing and I don't think there's anyone in their right mind who—what we're saying is that we're selling these cigarettes to addicted people. We didn't make them addicted. They were already addicted before they go to us. Youngsters are buying their tobacco from the guy who sells the drugs in the high school. I have never seen any statistics to say, "Well, if you do this symbolic gesture, a health professional doesn't smoke"—it used to be very common that pharmacists smoked right in the dispensary. It was very common that doctors smoked as well. We've stopped all that. There's no smoking in pharmacies. We've done what we can.

However, it comes to a point where we can't go any farther and I'm not sure whether just taking it right out of there is going to stop one smoker. If taking it out of pharmacies puts 10 people out of work, people whom I work with and I like very much and I can't see them getting another job, then I think we've done more harm than we have actually helped anyone.

**The Chair:** I regret that we're out of time but I want to thank you for coming before the committee and for your written presentation as well.

KAREN GRAHAM

**The Chair:** Next is Miss Karen Graham. Welcome. We have a copy of your presentation, so please proceed.

**Ms Karen Graham:** Thank you very much, Mr Chairman, committee members, ladies and gentlemen, for the opportunity to express my opinion on an issue which I've followed with interest for the past few years.

I've been a pharmacist in Ontario since 1980 and I've been very fortunate to have practised in a number of different pharmacy settings, including community pharmacy practice, hospital pharmacy practice, the Ontario Hospital Association and the pharmaceutical industry. I now view my profession from the vantage point of a health consultant as Panacea Consulting. I'll be very brief in my remarks this afternoon.

I'm here to speak in support of Bill 119 as it relates to



the sale of tobacco products by pharmacies. I commend you on this initiative. I believe that this progressive legislation will lead the way to improved regulation of tobacco across the country, particularly as it relates to the sale of products in pharmacies.

My personal involvement in the tobacco issue began with the Canadian Society of Hospital Pharmacists through which, as a board member, I personally initiated resolutions on this issue. Both the Ontario and national organizations have passed resolutions at their respective annual meetings which clearly articulate a position against the sale of tobacco products by pharmacies. These associations represent some 2,000 pharmacists across Canada, 1,000 of whom practise hospital pharmacy in the province of Ontario.

As a registered pharmacist I've also written to my professional licensing body, the Ontario College of Pharmacists, to encourage action against the sale of tobacco products by pharmacies. As well, I've attached to the brief that I supplied for you a copy of the letter published in the *Globe and Mail* recently in which I expressed my personal support for your legislation.

I believe that this is a very simple issue and I'm disappointed that attempts to encourage voluntary withdrawal of tobacco products from community pharmacies have largely failed. It now appears that legislation is the only way to end a conflict of interest which in my opinion has been an embarrassment to my profession for far too long.

Tobacco products are lethal. Pharmacists have a duty to the public to promote health and prevent disease. Pharmacists who practise in settings which sell tobacco products not only profit from the products themselves but they also profit from the sale of medications used to treat nicotine addiction, as well as medications used to treat the inevitable consequences of tobacco use, including asthma, lung cancer and other malignancies of the respiratory system, emphysema, bronchitis, coronary artery disease, cerebrovascular disease etc. The list is very long.

Many pharmacies across Canada have either never sold or have voluntarily withdrawn tobacco products and to my knowledge none has gone out of business. In fact, the Canadian Pharmaceutical Association published a study in 1992 of 56 pharmacies which had eliminated tobacco product sales: 59% had no income loss or actually saw an increase in overall sales, 13% had marginal losses and 7% had moderate losses. Of those 20, all had recouped their losses by the end of two years.

Pharmacy associations have supported the voluntary withdrawal of tobacco products. Sadly, in view of the relatively low number of pharmacies which have complied voluntarily, it appears that legislation is now necessary. The profit motive must never be served ahead of the professional motive, to promote health and prevent disease. Pharmacists exist to meet the drug-related needs of our patients. I believe that arguments based on the freedom to compete in a retail environment should be relegated to retailers, not supported by professionals. As a pharmacist I really believe that we must observe our moral imperative to first do no harm.

**The Chair:** Thanks for the attachments to your brief. We'll begin the questioning with Mr Arnott.

**Mr Arnott:** Thank you for coming here. It's good to hear from Erin township. I want to tell you that you're not the only one in Wellington county who's taken this view. I did a major survey of everyone in Wellington county back in the summertime and I raised the issue of the discussion paper that the government had released. I gave the whole story and suggested there's a possibility that the pharmacies are going to lose their ability to sell tobacco if this bill goes through. The response in Wellington county to the question, "Do you support the government's plan to impose stricter regulations governing cigarette smoking and sales?" was this: 58.5% yes, about 31% no, so a significant majority for what we're saying.

Also in Wellington county we know that we have some small towns with pharmacies, and in those small towns the pharmacy is an important component of the local health care system. We don't want to lose any of our pharmacies. If some are sort of on the borderline and they need that sale of tobacco and they tell us this, what do we say to them?

**Ms Graham:** I believe that the loss of business due to the decreasing sale of tobacco products is really a red herring. Based on the information available from the Canadian Pharmaceutical Association and my understanding that no one has gone out of business who has either never sold tobacco products or who has recently stopped voluntarily selling them, I think that's a spurious argument.

**Mr Wessinger:** Thank you very much for your presentation. I really appreciated your comments and I think you outline the dilemma that everyone faces, especially with self-regulating professionals, the dilemma between ethics and economic self-interest. I think all professions face that and I gather you feel that the ethical considerations should prevail over the economic considerations.

Would you also extend that to the whole question of tobacco? Do you think the ultimate goal should be the elimination of the tobacco industry and elimination—Utopian, of course—of tobacco consumption? Is that a worthwhile goal pursuing?

**Ms Graham:** I think it's entirely worthwhile and highly Utopian. It's a complex issue. I'd like to add, in terms of the retail versus profession issue, I think that pharmacists have been forced to become retailers in order to survive as businesses, in some cases small businesses, and I think a related issue to this whole argument is how pharmacists are reimbursed for their services. That whole issue really has to be looked at, obviously not in this forum, but I don't want to leave the impression that I'm naïve enough to think that if pharmacists did no retailing they could survive. In today's environment they couldn't, in the community pharmacy setting. That's a side issue, I suppose.

**The Chair:** Thank you very much, Ms Graham, for coming to the committee today.



## A&amp;P DRUG MART LTD

**The Chair:** If I could call on our next witness, the representative from A&P Drug Mart Ltd. Welcome to the committee. We have a copy of your brief. If you'd be good enough to introduce yourself and then have some fresh Toronto water.

**Mr Phil Rosenberg:** Chlorinated?

**The Chair:** Yes. Who knows what's in it. Welcome to the committee and please go ahead.

**Mr Rosenberg:** Mr Chairman and honourable members of the committee, good afternoon and many thanks for the opportunity to address the tobacco issue and Bill 119. I'm Phil Rosenberg, general manager and director of A&P Drug Mart Ltd. I represent not only A&P Drug Mart, with 25 pharmacies located within 25 of the 245 supermarkets owned by A&P Canada, but unofficially I speak as well for the non-traditional pharmacy segment, that is, Woolco, K mart, Zellers, Loblaws etc, all of whom have pharmacy departments within the confines of much larger stores, be they supermarkets or department stores. By the way, A&P Drug Mart is a contributing member of the Ontario Chain Drug Association.

As a professional pharmacist conscious of the health factor and the related costs, it would be extremely difficult to argue against a smoke-free society. As well, if pharmacy in Ontario is limited to an apothecary approach, that is, the dispensing of prescriptions and the sale of OTC—over-the-counter—products only, it would be much easier to resolve this tobacco issue.

The ultimate solution, as far as I'm concerned, would be the total ban of tobacco products from sale in Ontario and even Canada. Next best would be the limiting of tobacco sales to exclusively government-operated tobacco shops, similar to the handling of liquor in Ontario, thereby creating a truly level playing field for all retailers.

Unfortunately, it's extremely doubtful that such a Utopian solution could be achieved. The elimination of tobacco from pharmacies will in fact do little to curb the use of tobacco in society, since these products will be available in numerous other types of outlets, and indeed some general merchandise type of outlets have already introduced tobacco products for sale in their locations as a customer draw. This is evidenced by the increased sale of cigarettes in gas stations, not to mention the proliferation of contraband product available that we keep hearing so much about. I won't go into any more detail in this matter, as it's been covered by numerous presenters at these hearings.

I feel it's essential that the standing committee look at the economic aspects of the practice of pharmacy in Ontario and indeed take into consideration the ramifications that might take place on the total prescription and medication delivery system which exists in Ontario today. Tobacco sales in pharmacies provide good cash flow and provide a reasonable amount of profitability, which helps offset the overall costs of running a pharmacy. The reduction in revenue could impact dramatically on hours of service and numbers of days of service provided by pharmacies as well. Similarly, hours available and wages

payable to staff pharmacists could be affected, especially in the more remote communities.

I'm sure you are aware that the number of tablets per prescription is increasing dramatically, as is the cost of all the newer medication being developed. These factors are contributing to lower profit margins and increased costs of inventory maintenance. While these are economic issues, they are also totally professional in nature. So is the prescription dispensing fee both professional and economic in nature. Yet the government of Ontario sets the dispensing fee for Ontario drug benefit prescriptions, and in spite of mediator reports recommending increases, escalating costs of manning the pharmacy dispensary have been totally ignored, with no fee increase allowed in almost four years. In fact, as a result of the social contract in 1993, fees were actually rolled back by 61 cents, or 9.43%.

The Ministry of Health looks at pharmacies as professional health providers in relation to this tobacco legislation, yet when government reimbursement for over-the-counter medication was changed in June 1992 under the ODB program, from payment of a dispensing fee to a markup on cost of product only, we were then considered merchants or retailers. But today, the government looks to pharmacies to provide pharmacy care, patient counselling, proper private counselling areas, drug usage intervention, tighter control on drug abuse etc, yet dispensing fees are being reduced. As well, more and more over-the-counter medications, once the domain of pharmacy, are now being granted GP, or general product, status and consequently can be sold anywhere. That's being done by the Canadian government.

Yes, pharmacy is both a profession and a retailer. I suggest that the government should leave retailing to retailers and that this tobacco legislation is an unwarranted interference in the marketplace for as long as tobacco remains a legal product—I repeat, a legal product.

Please be advised that there are over 160 pharmacies in Ontario operating as non-traditional pharmacies. The major players are Zellers, with 70 pharmacies in Ontario; K mart with 10; A&P with 25; Woolco with 29; and Loblaws currently with 17, plus others in various department stores.

Within the over 150 pharmacies outlined above, there's currently a total of 183 full-time pharmacists, 199 part-time pharmacists, 69 full-time pharmacy assistants or technicians and 192 part-time pharmacy assistants or technicians. In addition, there are a large number of head office positions in place for these non-traditional pharmacies; ie, administrative, supervisory, merchandising, secretarial, bookkeeping, payroll, accounting, finance, buying, benefit clerks etc. I must say that some of the part-time pharmacists and pharmacy assistants do overlap and in fact work in more than one store, and might perhaps be working part time for me as well as for Woolco. That we don't know direct numbers on.

Many of the non-traditional pharmacies mentioned are either franchised or subleased, or they may be wholly-owned by parent company, but in all cases the pharmacies are a small department within a much larger retail

operation. In none of these operations does the pharmacy get involved in the sale of merchandise which doesn't relate directly to prescriptions or over-the-counter medication, nor does the pharmacy have any say or control over what is carried elsewhere in the store. As well, the consumer realizes that the pharmacy has nothing to do with the sale of tobacco, tires, furniture or even lettuce that may be offered for sale in these non-traditional stores where these non-traditional pharmacies are located.

It is not in my jurisdiction to guess which way the decision by upper management of these various retailers would go as to the removal of pharmacy service or the cessation of the sale of tobacco products in these non-traditional pharmacy stores if Bill 119 is passed as is. I do know that a great many prescription patients will be deprived of convenient and satisfactory prescription service if the parent retailers opt for tobacco sales over maintaining prescription departments.

Worse yet would be the tremendous unemployment created in Ontario if these non-traditional pharmacies were closed. Allowing for the smaller non-traditional pharmacy players in addition to the previously listed stores, over 200 full-time pharmacists, 150 part-time pharmacists, 90 full-time assistants, 200 part-time assistants and office staff would all be pushed out into the job market at the same time.

What would have been accomplished? Inconvenience for many prescription patients, including a great number of seniors who enjoy visiting these larger establishments as an outing; a shifting of tobacco purchases from pharmacies to other retailers such as convenience stores and gas bars where controls may be much less stringent; a greater squeeze on traditional pharmacy cash flow and profitability; the tremendous potential impact of unemployed pharmacists and related personnel which could result.

A truly level retail playing field, as far as the retail sale of tobacco is concerned, could prove to be essential to many of our current pharmacy owners, as other forms of retail would benefit by the legislation as proposed.

While it is my belief that the legislation is well intended and might enhance the image of pharmacy, I'm extremely concerned that the legislated implementation of such a ban would result in major resentment towards our provincial government by many of the group members and perhaps even result in some lawsuits as well. Voluntary cessation of the sale of tobacco products by individual pharmacy owners, based on their own personal ethics and economics, makes much more sense.

To increase the age requirement for the purchase of tobacco products, to launch an extensive educational program aimed at our youth and expectant mothers, to increase fines for sales to minors and impose penalties in this regard, and all the other provisions in Bill 119 are well founded and should be proceeded with immediately.

I know you have had many similar submissions already over the last few days—the Coopers and Lybrand study, the Lindquist study, the Committee of Independent Pharmacists, the Ontario Chain Drug Association, as well as many others—which all indicate the tremendous negative impact Bill 119, as it exists, will have on

pharmacy economics—reduced customer counts, loss of companion sales, potential job loss, potential pharmacy closings, loss of pharmacy revenue and so on—only to drive tobacco sales to other retail vendors or to more underground sources.

The true intent of Bill 119, to reduce smoking and strive for a smoke-free society, will not be achieved by removing the sale of tobacco products from pharmacy. Please pay heed to the economic arguments put forth by the previous pharmacy presenters as well as to this brief.

In addition—and this is not in your notes—to having a pharmacist on board at A&P, there are other positive implications at A&P which the Ontario College of Pharmacists could back up. As you know, they're involved with compliance etc. Any questions they have about food stores carrying products that perhaps they shouldn't or are questionable, if there are pharmacies involved in those food stores the situation is resolved immediately.

#### 1530

Very recently, we had a complaint called in to A&P stores to our customer complaint department, basically, and it was as follows: Recently, two minors, age 15, were interviewed on a popular Toronto radio show and stated that one of our stores is where they can purchase their tobacco products. An irate customer called and asked how this could be. Immediately on January 24, a letter went out from the vice-president of operations of each of various banners to the store manager.

“Subject: Sale of tobacco products to persons under the age of 18.

“As you are aware, it is illegal to sell cigarettes or tobacco products to any person under 18 years of age. Recently two minors age 15 were interviewed on a popular Toronto radio show and stated that one of our stores is where they can purchase their tobacco products.

“It is essential that every one of our cashiers, both full-time and part-time, are totally aware of the legislation and adhere to the law regarding the sale of tobacco. New signs will be sent out once again concerning the sales restriction and should be posted in the counting room, lunchroom, near the time clock, as well as in the tobacco sales area.

“In addition, each manager should read this letter and acknowledge understanding of the legislation by signing the letter below and returning same to your district manager. Your immediate attention to this matter is appreciated.”

We didn't just go with the little government signage, which as you know is probably a red square, four by six. No, we go much higher and we try to get the message across. I feel it's the influence of professional pharmacists involved in department stores and in the supermarkets that create things like this to happen. I think Bill 119 jeopardizes that fact.

In my humble opinion, the pharmacy restriction should be totally removed from the legislation with a move towards a total ban or a government-controlled tobacco sales environment. Such action would be deemed as much more realistic by both the profession and the public



sector. At the bottom of my presentation, there's a chart with the larger players, Woolco, Zellers, K mart, Loblaws etc with how many pharmacies they currently have in Ontario. There are others planned. I know our company has several on the books. Loblaws intended to have 25 by the end of 1994. Zellers has three on the books currently and there you have the full-time and part-time pharmacists and assistants that are currently working for us.

I didn't bother checking with some of the smaller players that have one or two pharmacies only in Ontario such as Eaton's, The Bay, Safeway, Knob Hill etc.

Thank you for the opportunity of speaking to you.

**The Chair:** Thank you very much. We'll try to work in two questioners.

**Mr McGuinty:** Thank you very much for coming forward. You've shed some new light on this issue of your non-traditional pharmacies.

While the government is trying to argue that the symbolism is very important in terms of people thinking of traditional drugstores as health care providers and there's something paradoxical about selling tobacco at the same time, I'm not sure how it could be argued that people think of Zellers or K mart or A&P or Woolco or Loblaws as a drugstore. I have a great deal of difficulty with that.

The other thing that you told us here today, and it makes sense, is that if your head office decides that it's going to shut down pharmacies—I'm not sure, I understand tobacco's a pretty profitable product—you cannot re-employ trained pharmacists, I gather, elsewhere in any of those stores. Is that correct?

**Mr Rosenberg:** That's very true. What are we going to do, ask a pharmacist to manage the corner Becker's store? "Take the night shift. You're used to working to 10 o'clock at night anyway so you might as well take the night shift and you can sell cigarettes at Becker's."

Pharmacists, as you all know, have four years' university education, plus internships, continuing education programs on the go that they adhere to. What are we going to do with all these people? They cannot go anywhere else. What else are they going to do? This is what they're trained for.

A retraining program for pharmacists who are scientifically trained would be an expensive tax burden, whether it's unemployment or whatever, the burden to retrain professional people like pharmacists or even pharmacy assistants who have gone to a community college, taken courses, have several years of experience working in a dispensary.

At A&P for instance, our pharmacy assistants belong to the store union, and for them to even apply for a pharmacy assistant position with us they must have graduated from a community college that is recognized with a pharmacy assistant diploma or they must have a minimum of two years' dispensary experience in a pharmacy. Where are these people going to go?

As you mentioned, the larger department stores, tobacco may be a large percentage of their volume. If you understand business, the cash flow in the tobacco business is tremendous. You have a very fast rate of turnover, and while you may only be making a 5% to 10%

margin, and I think you heard those figures earlier, the fact that they're turning over so frequently, your direct profit on that item—and if you've had any accountants' studies, direct profit on any particular item has a major impact on cash flow and the amount of financing you require to carry a product.

I mentioned the inventory in dispensaries is going up, with the new cost of drugs. The turnover in dispensary inventory is very low, in fact. So it is a matter of economics, and I'm here just to talk economics. From an ethical and moral point of view, that's something else. But from an economic point of view and especially with non-traditional pharmacy, I really don't know which way the decision will be made by these major players.

You've got Wal-Mart coming in. They have pharmacy and tobacco in all their stores south of the border. What's going to happen here? I don't know. The Zellers situation, they're ready to open three more stores. Loblaws has eight more on the books by the end of this year. We have two that I know of for sure and we're looking at two or three others. Are we going to put a stop to this type of pharmacy? Our types of pharmacies, in many rural communities, are very, very important and very popular.

**Mr Jim Wilson:** Thank you for your presentation. As Mr McGuinty has pointed out, you do shed some new and interesting light on it.

I had no idea there were some many non-traditional pharmacies. I didn't know Zellers had 70, for example, Woolco at 29, K mart at 10, Loblaws at 17, of these types of pharmacies.

I think yours is the clearest example of the fact that people who walk in don't associate the jeans in the Zellers store with the drug product back at the drug counter. Clearly, your customers must know the difference between the drug counter and the retail store that they're in. You even mentioned lettuce, and I'm glad you mentioned lettuce.

**Mr Rosenberg:** The consumer mindset is such that the pharmacy is a professional department regardless of where it's found. My pharmacists do counsel, they do go out and speak to senior citizens' groups, they go out and speak to schools.

You can walk into any pharmacy in most of these department stores, I'm sure, and in most of these supermarkets, and there is counselling material on tobacco available, including videos that you can take home with you, pamphlets, whether they're our own or whether they're supplied by a patch manufacturer or what have you. They are there and the pharmacists are available to counsel.

**Mr Jim Wilson:** We've heard the average markups in pharmacy, and particularly as Health critic, I know where that trend is going: less and less profitable. In fact, if I were a retailer, and my family's been in retail for a number of years, I'd pick the cigarette counter over the pharmacy counter when you see the profits in cigarettes.

I know pharmacies, for example, have been using dispensing fees as loss-leaders. They're losing money on their pharmacy as far as I can tell, and I've had phar-



macies come in and say they are. If I were you and your fellow colleagues, I would be extremely worried about this decision.

It's pretty hard to squeeze profitability out of a pharmacy counter when your prices are controlled by government to the best available price plus 10%, so I don't know where you're going to go on that.

If I was in retail looking for a loss-leader and knowing that other pharmacies are being knocked out in the same mall, if I were Zellers, I'd double the cigarette display and try and get some profitability out of that and use cigarettes as loss-leaders. What do you think of all that?

**Mr Rosenberg:** I have to agree with you. I did a quick study this morning at the office. I pulled off some tobacco sales for the last few weeks and I transformed that into a year's tobacco sales compared to what my pharmacies do in a year. I looked at the margin kickout on tobacco and it's less than 10%.

By the way, I may get shot, but our tobacco sales at A&P are 40% of what they were before the advertising legislation came into place, and that's good. They're 40% as of this morning, and I'm looking at the last few weeks' sales.

I looked at the profitability based on approximately 5% margin on tobacco—and that's low, because many people make 10%, but I took 5%; I wanted to be on the safe side—and in our 243 stores, because there are 243 of them compared to 25 pharmacies, the annual profitability on the tobacco far exceeded my contribution last year.

**The Chair:** I'm sorry that we're out of time, but I want to thank you for coming before the committee this afternoon.

1540

HAMILTON-WENTWORTH  
HEALTH AND SOCIAL SERVICES COMMITTEE

**The Chair:** If I could then call on our next witness, Mr Dominic Agostino. Welcome to the committee. If you'd be good enough to identify yourself and then please go ahead with your presentation.

**Mr Dominic Agostino:** My name is Dominic Agostino, chairman of the health and social services committee of the region of Hamilton-Wentworth. I am pleased to be here today along with Jim Ford, our chief public health inspector in our department of public health services, who has played a hand in preparing. I think it's better if he comes up to the front. If there are questions, he can probably answer much better than I could.

Thank you for the opportunity to be here. The Hamilton-Wentworth health and social services committee and council fully endorse the short- and long-term goals and objectives of the Ontario tobacco strategy. The proposed act, Bill 119, is a very good piece of legislation in principle and clearly demonstrates the Ontario government's commitment to protect the public, and especially our youth, from tobacco, which is a hazardous and addictive substance. The Hamilton-Wentworth health and social services committee's recommendations concerning the proposed act support the attainment of the Ontario tobacco strategy goals.

One of the biggest difficulties in the fight against

tobacco I believe to be the multibillion-dollar direct and indirect recruitment of young people by the tobacco companies, which clearly shows the need for legislation from all levels of government to deal with this. Provincial, federal and municipal governments must attack this issue head-on as it is unquestionably an immoral, unethical and deliberate inducement of young people to begin smoking. It is obvious that the tobacco industry needs recruits, and unfortunately they are succeeding.

We are seeing an increase in the number of young people who are smoking. It is obvious that if this trend is allowed to continue, the current number of deaths related to smoking in Ontario, which appears to be about 13,000 per year, will continue to increase. All levels of government must attack this issue head-on. I believe the time for pussy-footing has to end. We must call a spade a spade on this issue. Tobacco companies cannot and should not be allowed to continue, through back-door advertising such as lifestyle, car racing, theatres and fashion foundations and other methods, to give messages to young people that tobacco smoking is acceptable. I believe this legislation is a part of that strategy, and I believe also we must do more.

We strongly support the increase in the legal age of purchase to 19. Increasing the age to 19 is a positive step towards putting tobacco accessibility on the same restrictive level as alcohol. All tobacco products are hazardous and addictive and should be treated with the same restrictions as liquor. Tobacco sales should be controlled, in our view, by a tobacco control board through government-run outlets or existing LCBO outlets.

If the sale of tobacco is to continue through existing retail outlets, then retailers must be made more accountable. A provincial licensing system with revokable licences is needed to motivate retailers to comply, fearing loss of revenue through licence suspensions, as is the case with alcohol. This would be self-financing from licensing fees.

The recruitment begins early. Most children start smoking between 12 and 14 years of age. Health and Welfare Canada surveys show that 90% of young smokers start before the age of 17. According to the 1991 Statistics Canada general social survey, 16% of teenagers between the ages of 15 and 19 are daily smokers. It is estimated that Canadians under the age of 19 consume over two billion cigarettes per year, representing an annual market of over \$400 million. It is difficult to deal with the problem once children become addicted, and tobacco is a powerfully addictive product.

We believe the use of the age-of-majority card currently used in Ontario provides easy identification for the purchaser of tobacco. It allows for an enforcement mechanism that prevents the retailer from selling to minors and inadvertently breaking the law.

I'll give you an example. In Hamilton we have legislation, licences and the same things as everyone else. On the weekend I took my 7-year-old nephew, who looks about 8, maybe 9 at the most, to two outlets, two different parts of the city, and asked him to go in and purchase cigarettes. In both cases he walked out of there with cigarettes. He's 7 but he's a big kid; he could pass for 9.

In both cases he succeeded in walking out of the store without any questions asked. I was waiting in the car, and then I went in and dealt with the retailer at that point. But this is a 7-year-old child. This is supposedly the type of awareness that is out there, and that to me is a perfect example of the need for stronger legislation that has to be effective and has to be enforced properly.

We're concerned about the enforcement, a mechanism that includes fines and bans on the sale of tobacco. The provincial government has not published yet at this point how it plans to enforce the Tobacco Control Act. We believe the government and opposition parties will ensure that there's effective and consistent enforcement. Without adequate enforcement the legislation will be ineffective. Enforcement of the legislation is essential for ensuring compliance and preventing access by minors. In Hamilton, when licensing was introduced, we were able to appreciate the enormity of the task of policing tobacco outlets. Licensing provided accurate information for policy planning.

Enforcement needs to occur at every level of government. The enforcement body needs to be strengthened to include public health inspectors, bylaw enforcement officers and provincial offence officers.

The third point I want to talk about briefly is the banning of tobacco in pharmacies and other health care facilities. It appears to have been a popular subject in the half hour or 45 minutes I've been here today.

As we are aware, approximately 25% of tobacco sales made in Ontario occur through pharmacies. We strongly support the banning of tobacco sales from pharmacies. The current level of tobacco outlets must be reduced. We support the banning of these sales. We believe the message that health care facilities and pharmacies should not sell tobacco should be consistent.

The major benefit of the termination of tobacco sales in pharmacies is the elimination of a conflicting message about the risk of tobacco products being sent to all people of all ages, but especially to the young. On one hand, health professionals are saying that tobacco industry products are the cause of 30% of cancer deaths, 30% of heart disease and 90% of lung disease deaths. On the other hand, government undermines the risk message by allowing these products to be sold and promoted in health care facilities, including pharmacies. The Ontario Medical Association has condemned this practice. Basically, the message that kids get is, "If it's okay to be sold in a place that we're supposed to go to to get better, where we get our medication, then it obviously can't be too bad a product." Pharmacists should not sell an addictive product that kills people.

I'll go past some of this. You can read it on your own and go along with the presentation. However, the absence of cigarettes from drugstores would encourage pharmacists to become full members of the health care team and, without their conspicuous conflict of interest, would enable them to engage in real counselling about the risks of tobacco use. I find it interesting where on one hand they're standing there selling products that are supposed to promote and help health and are counselling against tobacco, and you walk to the other end of the store and

they're selling the same products that they're counselling you as to the risks of. Clearly there's a mixed message there that comes out loud and clear. To me, it is really unethical for pharmacies to be involved in selling products that are clearly harmful if used as intended. This piece of legislation should ban that and make it quite clear and send a very consistent message.

We support the banning of vending machines from the sale of tobacco. We believe it will control access and will also control the sales as far as the age. We support the health warnings and age limits on premises. We think that is an extremely important part of the legislation that continues to send out the very positive message.

The aspect of prohibiting smoking in designated places and all health facilities except residential facilities: The provincial goal to make all schools, workplaces and public buildings smoke-free by 1995 will in our view not be accomplished by the proposed Tobacco Control Act. The hazardous effects of environmental tobacco are well established. On page 5 of the original discussion paper of the Ontario Tobacco Act in January 1993, it was stated, "Places where people routinely go for their day-to-day activities should be free from this environmental health hazard."

Eliminating smoking from all workplaces, all public places and all health facilities is the only way to protect the public from needless exposure to environmental tobacco smoke. Non-smokers in Ontario comprise 73% of the population. Legislation should protect the public by making smoke-free space the norm in Ontario. This is the most effective short-term means of reducing consumption, and then smuggling and the other problems that come with that.

The aspect of requiring health warnings and other information on tobacco packaging: We endorse the province's intention under this act to require additional health warnings. Federal health warnings on tobacco packages should be reinforced by provincial legislation. Children and adolescents, like the population in general, have a generalized awareness that smoking is bad for you. Beyond the superficial level of awareness, most young people have no idea of the nature of the risk or the magnitude of the danger associated with tobacco products. Kids aren't aware of the increased risk of diseases caused by smoking, the prognosis for such illnesses, and the impact of quitting smoking on these risks.

Because tobacco products kill when used as intended and because the industry has been totally negligent in informing its customers as to the serious risks to which smokers are exposed, Canadian governments at all levels should assume responsibility for informing tobacco users and potential users of the consequences of tobacco use.

In partial fulfilment of this responsibility, the federal government, via the Tobacco Products Control Act, requires manufacturers to carry the warnings which are currently printed on tobacco products. What is not widely known is that these warnings establish minimal standards for tobacco warnings in Canada. In fact, subsection 9(3) of the TPCA allows the provinces to require more stringent and better-targeted provincial warnings.

What is surprising is that even though the federal



government almost invites the provinces to give children, adolescents and existing smokers better warnings; to date not a single province has gone far enough to do so.

1550

My recommendation on this issue would be very simple: that tobacco products be sold in plain brown packages with black lettering identifying the brand and other pertinent information on one side of the package, and on the other side in very clear, bold letters, the following line, "This product, used as intended, will severely harm your health and can kill you."

One other brief point, and that is, I urge the government and this committee to do everything possible to discourage the federal government from what I believe to be a very wrongheaded, short-term quick fix to a bigger problem by trying to reduce taxes. I think it is absolutely ludicrous to compromise and risk the health of young people, particularly through making cigarettes more affordable. Although it's not related to this committee, any message that can go out that way I think would help everyone across the province. Thank you, and sorry for being a little longer.

**The Chair:** Thank you. I want to try and work in two questions: Mr Wilson and Ms Haslam.

**Mr Jim Wilson:** Thank you, sir, for your presentation. Most of what you said I could and do agree with. As you know, having been in the room for a while, we're somewhat bogged down with the issue of banning the sale of tobacco products from pharmacies, and you said, as many other presenters have said to us, that pharmacies should not be selling products that kill people.

I'd ask you, what do you think pharmacies do and why do you think we have them? One of the primary reasons, of course, is we entrust them with products that kill people. That's why we have restricted products and people go to school for four or five years to learn how to handle those products. We put them behind counters so they're not readily accessible. One of the decisions Health and Welfare Canada makes in making the decision whether it's going to be an over-the-counter drug or a behind-the-counter drug is, how will this kill you and to what effect can it kill you and can we trust the public to do it without counselling and without prescription?

Following on that logic, then perhaps we should be moving cigarettes into pharmacies and putting them back where prescription drugs and all the other stuff that can kill you are dispensed.

**Mr Agostino:** Very clearly there's a distinct difference between the two. The products that are sold behind the counter, if taken as prescribed and if taken appropriately, will not or should not harm your health. A problem with medication is that if it's overdosed or taken improperly, then it will harm your health. Clearly, that same standard does not apply to tobacco. There's no safe level of tobacco smoking. There's no proper level or proper way of tobacco. Any type of tobacco smoke is going to harm you. I see a clear distinction between the two: One, if used properly, is going to help you; the other one, if used properly, is going to ultimately kill you.

**Mr Jim Wilson:** Okay, but today's context is that

tobacco is a legal product. It is a poison. Shouldn't it go where all the other legal poisons are kept in our society?

**Mr Agostino:** To me, I do distinguish clearly the difference with the other poisonous products that you're talking about, if used improperly. If somebody's got a virus and they go in and get an antibiotic, that is not a poisonous product in the sense that if used properly, it's going to help you and it's going to make you better. I don't know how you can apply that same principle to cigarettes in any way, shape or form.

Very clearly, it's the message they're sending out. I understand that people will get cigarettes elsewhere. You're not going to stop somebody from smoking because they're not available in the drugstore, "I'll go to the Becker store at the corner," but it's that consistent message that we're trying to send out that it's a health issue, and to do it in a facility where they're there to promote better health I think is hypocritical and ludicrous.

**Mrs Haslam:** I understand what you're saying about taxes. I certainly will be writing my letter to Mr Chrétien, not that he's going to listen to me.

**Mr Agostino:** I've written mine as well.

**Mrs Haslam:** Oh, good. I want to talk just very quickly, and I know time lines are very hard, about the idea of enforcement. On page 5 you said that licensing was introduced. Do you find that more effective? Why do you think a licensing system would be more effective—or do you?—than what is presently presented in this legislation?

**Mr Agostino:** A licensing system I think would give a very clear mechanism and a very clear sort of, "If you don't do it, here's what's going to happen." I mean, what we have done in Hamilton is an example. We've just started a mechanism where you have to be licensed to sell tobacco products. Very clearly, the threat at the end of the process is if you're selling tobacco products to minors, then we can pull that licence and that ability for you to sell tobacco.

**Mrs Haslam:** More effective than the statutory model that is now present?

**Mr Agostino:** I think this could work as well. I'm not suggesting it's more effective. Also, we want a deal. Our ultimate goal would be to have it through some controlled mechanism, like the LCBO, under the control board. That ultimately would be the goal we would want to look at, to add to that. But clearly what is here is a step in that same direction.

**The Chair:** Thank you very much for coming before the committee today.

BARRY PHILLIPS

**The Chair:** If I could call on Mr Barry Phillips, welcome to the committee. For committee members, Mr Phillips does not have a written presentation.

**Mr Barry Phillips:** I apologize for not having it with me.

**The Chair:** That's quite all right.

**Mr O'Connor:** That's all right. Save a tree.

**Mr Barry Phillips:** I saved a couple of trees.



I want to thank you for the opportunity to present to you today. My name is Barry Phillips and I'm a licensed pharmacist. I am the owner of the Shoppers Drug Mart at Royal York Road and Bloor Street here in Toronto.

I am also the immediate past president of the Ontario College of Pharmacists. I finished my most recent term as president last October. I was also president of the college in 1985, so I guess I am both the past president and a past president. I know you've had a lot of them around. I am also a past president of the Pharmacy Examining Board of Canada. I have served as a college council member since 1977 and I am currently on the executive of the college. I am presently the chairman of the bylaws and legislation committee and the quality assurance committee.

I must make it clear, however, that I am not here representing a college today. I am here as a pharmacist and retailer on behalf of my staff and myself.

Like many of the other presenters before the committee, I also congratulate the government on Bill 119 and the measures it includes to prevent young people from starting to smoke. However, I am strongly opposed to the pharmacy ban in Bill 119.

I believe that there is no public good achieved by removing tobacco from pharmacies and that it would lead to a serious decrease in the public's access to pharmacy services. In the end, the interests of the public will not be served, nor will there be any resultant decrease in the amount of smoking.

As a member of the council of the Ontario College of Pharmacists, I am elected by pharmacists in my district. However, my role at the college is to protect and serve the interests of the public and not to address the interests of my fellow pharmacists.

There are often issues that raise conflict between the interests of pharmacists and the interests of the public. The college has dealt with many such conflicts in the past and I'm sure that we will have many more in the future. Although it has seen much more media attention than many issues we deal with, the tobacco issue is not unique in that regard.

As a member of the council of the college I've been involved in many issues of public policy in the past. For example, in the next few months the council will be involved in the development and codification of standards of practice for all pharmacists in this province to ensure that every Ontarian receives the best possible pharmaceutical care from their pharmacist. The role will be expanded in that all pharmacists will be required to fulfil consultation requirements on all new prescriptions and, when necessary, on refill prescriptions.

It is widely accepted that the pharmacist is an underutilized health care resource. This resource should be tapped to improve the level and promotion of health care in this province. In the same fashion, the pharmacist has a significant role to play in the solution to attain a smoke-free society, rather than be excluded. Pharmacists every day counsel patients on the proper use of medications. This resource should and is being harnessed on the sale of nicotine chewing gum and patches by providing

education and counselling to the smoker about the perils of smoking and the options for quitting.

In any other locations that sell tobacco, such as gas bars and convenience stores, there is no literature on cessation options available for the smoker who wants to quit. Most pharmacies make this type of information available. Certainly, I do in mine.

I have been embroiled in this debate for over three years at the college and I have yet to see any evidence that banning tobacco in pharmacies will have any health care benefits. There is no proof that even one person will stop smoking as a result of a ban in pharmacies. In fact, the health care groups that have appeared before you agree that it will not reduce consumption. To them, it is a symbolic gesture. What, I ask, will it actually accomplish?

**1600**

There is, however, compelling evidence that the economic repercussions on local community pharmacies will be devastating. I have heard story after story from my colleagues and the pharmacists in my district about the tremendous pressures they are experiencing in their businesses from the recession, Ontario drug benefit deletions and the social contract.

The independent pharmacists presented the Coopers and Lybrand study that shows there will be 119 pharmacies, many in small communities, that will be forced to close. This means the public will be underserved and there will likely be whole communities that will not have a pharmacy. I cannot with conscience support a decision that will restrict the public's access to pharmacy services. This is not at all consistent with the mandate of our profession.

From a public policy point of view, I have to ask where the pharmacy ban fits. It will not lead to a reduction in smoking or even a better level of control over the sales to minors. It appears to be an appeasement to the non-smoker advocacy groups, with nothing to do with the broader goal of reducing consumption of tobacco.

Many of the non-smokers' advocacy groups that have appeared before you have tried to link the tragedy of tobacco-related deaths to the sale of tobacco in pharmacies. Certainly, the tobacco epidemic is a tragedy. However, these interest groups are trying to use an outrageous argument to appeal to people's emotions and to get your attention. I think that is grossly unfair to pharmacy operators. I personally find this to be a completely illogical argument, simply because the smoker has many retail outlets to purchase tobacco and one retailer cannot be singled out as responsible.

Speaking of singling out one type of retailer, in the past Shoppers Drug Mart has been the victim of sting operations by the non-smokers' rights organization in an attempt to entrap our employees, by disguising a young person and having them try to purchase tobacco in our stores. In fact, we are concerned that they are about to undertake another sting operation in the next few days while these hearings are under way.

I attempt to be very diligent in instilling in my employees the necessity to make absolutely sure they are

not selling tobacco to minors and to refuse the sale if there is any doubt whatsoever. At my last staff meeting on Sunday, we once again discussed the issue and I alerted them to the possibility of a further sting attempt. We have a training video for my staff and a declaration they are asked to read and sign when they are hired. They are well aware that if they knowingly sell tobacco to minors, they will be disciplined or even dismissed.

We keep hearing from health care groups about the inconsistency or paradox associated with pharmacies selling tobacco. These inconsistencies would easily be resolved if tobacco was sold as a controlled substance in pharmacies or in a similar controlled environment. Pharmacists are faced with paradoxical situations based on the products we sell on a regular basis. For example, the college has endorsed the sale of needles and syringes by pharmacists to drug addicts. In fact, the Ontario government sponsors needle exchanges in a non-judgemental atmosphere. As we all know, street drugs are a very lethal product, and the provision of needles to addicts certainly raises the same ethical issues.

Pharmacists sell contentious and dangerous products every day. That is why we have so many regulations and requirements of pharmacists. That is why we have standards that must be met before a pharmacy can be licensed or a pharmacist can practise in this province. We already have a well-established environment for the sale of controlled items, so it follows, if the government is truly concerned about the control of tobacco, pharmacies would be an ideal place for its controlled sale.

The idea of a tobacco control board, similar to the LCBO, has been raised as another option to control its sale, especially to young people. As we are very much aware, if a person does not start smoking before 18, the chances are very low that they will ever smoke. I believe these are two viable options available to the government if it is really serious about having a smoke-free society in Ontario.

Paragraph 4(2)8 in Bill 119 exists to a large extent because of the resolution that was passed at the college almost three years ago. The Minister of Health has openly stated that the government is acting on the wishes of the Ontario College of Pharmacists. The implication is that she is also acting on the wishes of the pharmacists in this province. I can tell you that is not the case.

However, you should be aware that it has been some time since the college asked the government to start a phase-in of tobacco withdrawal, and I feel very strongly that it should be aware of these events.

In October 1990, the Non-Smokers' Rights Association held a press conference to announce their attack on the profession of pharmacy and the sale of tobacco. I was quite startled by their use of the public forum to initiate this issue.

Messrs Mahood and Ronson were subsequently invited to a college council meeting. It was decided very quickly that a task force should be struck and during the next few months the committee consulted with many health care groups. I must add that many pharmacists appeared before the committee in council to voice their opposition to a ban.

Nevertheless, in June 1991, the Ontario College of Pharmacists passed a resolution to ask the Minister of Health to phase out the sale of tobacco in pharmacies. I was a member of council at that time and I voted against the resolution, for the same reasons I have enunciated now.

In August 1991, the Ontario college held elections to council. Eight council members who supported the resolution lost their bids for re-election and the incoming councillors were elected primarily because of their belief that the removal of tobacco should be a voluntary decision made by the pharmacist, depending on his or her personal circumstances.

The council is very clearly divided on this issue, and both sides have become fully entrenched in their positions. There are many members of council who would really prefer if the whole issue would go away. There is a great deal of reluctance on the part of many of my council colleagues to wade back into this controversial issue. I can understand their reluctance and sympathize with their dilemma. Many feel that what is done is done, that now it is in the government's hands and that it is not our job to further debate the issue.

However, I believe there is too much at stake, and that is why I am appealing to this committee. It is the job of this committee of the Legislature to consider the impact this ban will have on the public's access to pharmacy services, as well as the economic health of pharmacies and any potential health care benefits. It is up to you to determine whether the cost in terms of jobs lost and economic hardship to community pharmacies will be offset by any public good. I know you will find that this ban will produce no benefits to the public and will, as shown by the independent pharmacists' report by Coopers and Lybrand, hurt the public access to health care. I thank you all very much for your attention and the opportunity.

**Mr Drummond White (Durham Centre):** Mr Phillips, thank you very much for your presentation. As a pharmacist and as a member of the college and in fact a past president of that college, the essential thrust of your profession as a health care profession is really to regulate and dispense substances which have a therapeutic range of some health benefit but which also have some danger involved, as Mr Wilson was pointing out with the last presentation. Many of the medications have tremendous health benefits but they also have some dangers. That's why they're prescribed medications. That's why they're not over-the-counter or available in a corner store.

What's the therapeutic range of cigarettes? Is there a therapeutic value to cigarettes?

**Mr Barry Phillips:** If you spoke to my 77-year-old mother-in-law, who has been addicted to cigarettes for quite a substantial period of time, and you asked her to stop smoking, as I have many times, and provided her with counselling and material on her smoking habit, as well as the fact that she has emphysema—as I said, I've really done the best I can. As a matter of fact, she doesn't like coming to my house because we don't allow her to smoke inside the house—

*Interjection.*



**Mr Barry Phillips:** —which is good in one way, yes.

**Mr White:** But she's not a pharmacist. You are.

**Mr Barry Phillips:** No, she's not, but—

**Mr White:** You are the one who determines the therapeutic ranges.

**The Chair:** Mr White, why don't you let the witness please answer the question.

**Mr Barry Phillips:** What I'm saying to you is that this is a product that is legal. Unfortunately, there are a number of individuals who are addicted to it and cannot stop smoking, and will not, and at 77 years of age, her feeling is that she doesn't want to stop smoking. That individual will be entitled to purchase that product.

I think the thrust is that the under-18-year-olds—we want a smoke-free Ontario in the near future. Unfortunately, my 77-year-old mother-in-law, if she keeps smoking, is not going to be around very much longer, so we won't have to worry about her polluting the air.

It's the 18- and 17- and 16- and 15-year-olds who really are the problem. We can't get those people started. I think it must be in a controlled atmosphere. It must be either in a tobacco control outlet or in a pharmacy behind the counter where there can be counselling, where it does provide that opportunity, where it does provide that control on the sale of drugs and the sale of tobacco.

1610

**Mr White:** Wouldn't it be contradictory for you to be selling a product which has no therapeutic value, behind the counter?

**Mr Barry Phillips:** Look at it in the same way as a needle and syringe that is provided to a drug addict. Certainly, the drug addict is not getting any therapeutic value out of the street drugs. He's getting a high and he'll probably kill himself a lot faster with the street drugs than he would with tobacco, and yet we—

**Mr White:** But you're not selling cocaine.

**Mr Barry Phillips:** No, but we sell the means for them to inject heroin and those types of drugs into their bodies.

**Mr Jim Wilson:** Thank you, sir, very much for coming forward, because the government has put a lot of faith in the fact that the council in 1991 passed the resolution asking for this ban. Many of us in private meetings have heard the controversy surrounding that and you've been very courageous and forthright in bringing that to this forum.

First of all, I would say there's no therapeutic value in cigarettes and that's not what's on trial here when it comes to this particular section. It is, to my party, a freedom of business issue, a survivability issue for some businesses and a discriminatory issue in terms of you can't or you shouldn't pick on one section of the retail sector over another when it comes to a legal product.

Having said all that, I'll go back to the pharmacy council. If that vote were to be held today—remember this whole thing hinges on the council asked for it and somehow this could decrease consumption if they ban this, particularly among young people—how would the vote go on the council, in your opinion?

**Mr Barry Phillips:** It's very difficult to say because we have a new council that was just elected and started in October 1993 and it hasn't come to a vote with this particular council, so I wouldn't even guess. It depends. A lot of people feel: "Let's ignore this. Let's not bring this up and let's just hope it goes away, you've got it, it's your problem now and we don't have to worry about it."

**The Chair:** I'm sorry. We're going to have to move on. Thank you very much for coming before the committee and for your presentation.

#### ONTARIO NATUROPATHIC ASSOCIATION

**Ms Patricia Wales:** Good afternoon, ladies and gentlemen. The Ontario Naturopathic Association is here to present a brief presentation in support of Bill 119 and some background information as to why we're even interested in that.

Naturopathic medicine emphasizes health promotion and disease prevention. The therapeutic approach is based on enhancing the healing response by supporting and stimulating normal body processes. A healthy diet, optimum levels of nutrients, adequate rest and exercise and a positive attitude are elements that all promote health. By contrast, low levels of essential nutrients, skimping on rest and exercise and using stimulants like tobacco cause health to deteriorate.

Naturopathic doctors focus on lifestyle choices that increase health reserves and that decrease the accumulation of toxic substances, so supporting all measures that remove exposure to smoke is consistent with our practice and the needs of our patients.

The connection between smoking and the killer diseases is well known and well documented. Cancer, lung disease, cardiovascular disease and stroke are the visible end results of repeated insults to the body, and smoking is one of the most common insults connected with that. However, there are many other effects of smoking that are also well researched and documented, but that may not be as well known.

The whole body is affected when people are exposed to smoke and the effects are cumulative. The smoker chooses to be exposed. The non-smoker is also at risk because of passive or involuntary smoking of environmental tobacco smoke.

The negative effects of smoking seem to be based on three physiological responses: the stimulant effect of nicotine, the constriction of blood vessels and therefore a decrease of blood flow that results, and the toxic effects of all the chemicals that are in tobacco smoke.

Parental smoking affects fetal development. Smoking mothers produce smaller weight babies, which have a higher risk of perinatal death. Expectant mothers who do not smoke but whose mothers smoked are also at greater risk of miscarriage than those whose mothers did not smoke. It's a significant finding.

Secondhand smoke has been linked to lung cancer in non-smokers and also to respiratory ailments in young children, infants and pets who live in the houses of smokers.

Fractures take longer to heal in smokers. Smoking reduces bone mass and contributes to the risk of



osteoporotic fractures. Smoking decreases the level of the very antioxidant nutrients that help protect against carcinogens, nutrients such as vitamin C, beta-carotene, vitamin A, vitamin E and vitamin B6.

Smoking depresses the immune system. It's also a major risk for oesophageal and bladder cancer, as well as the mouth and throat cancer we'd suspect. Smoking contributes to skin aging and wrinkling and to low back pain, probably through malnutrition of the disc making it vulnerable to mechanical stress.

Smoking is correlated to a long list of physical complaints, things which all of us can be aware of in ourselves: coughing, sore throat, increase in phlegm and sputum, loss of appetite, stomach pain and ulcers, diarrhoea, heartburn, gum problems, bad breath, shortness of breath, itchy skin, pale face, palpitations, feeling flushed or feverish, back pain as we mentioned, weakness, fatigue, irritation, sensitivity or nervousness.

Health education should and must focus on the many complaints that people can monitor and prevent themselves, not just on the end result killer diseases.

Tobacco is a highly addictive substance. That's been well researched and documented, but it's also evidenced by the speed with which new smokers habituate to smoking and the great difficulty they experience when they attempt to quit.

As we've heard here today, 90% of smokers become addicted before the age of 20, so one of the most effective ways to reduce the damaging effects of smoking on health is to prevent teenagers from starting. Bill 119 addresses this by taking affirmative action to reduce the supply of tobacco products to minors.

Another important step to reduce the effects of smoking is to reduce the number of people who are affected by smoke, and Bill 119 addresses this by removing smoking from public places and health facilities, protecting the health of people who choose to be smoke-free.

The biggest hurdle is probably the addictive nature of smoking. By limiting outlets for sale, Bill 119 makes purchase of tobacco products less convenient and accessible. Licensing of outlets would go even further to control that access.

Warnings on packages presently keep the message of health hazard before the eyes of the users, which obviously they all choose to ignore. With teenagers influenced by the presence of tobacco companies at many major events, plain paper packaging would reduce the carryover effect of such advertising.

Naturopathic medicine provides effective programs to help people stop smoking. Antioxidant nutrients, specific botanical medicines, acupuncture treatment and focused relaxation techniques are of significant effect in breaking the smoking addictive pattern.

The success of any stop-smoking program depends on the personal motivation to quit. Even more important than that, probably the single most important factor is preventing people from starting in the first place.

Besides all the things we have talked about today, another really important factor in prevention is looking at the reasons, physiologically and psychologically, that

cause people to start in the first place. We need the combined efforts of public, government and business to reduce this identifiable and removable health hazard. The colossal cost of tobacco-related diseases in human lives, quality of life and health care dollars has been well enunciated by the chief medical officer of health.

The Ontario Naturopathic Association wishes to voice its support for Bill 119 and state that further provisions to license tobacco outlets and to require plain paper packaging would also receive our support.

1620

**Mr Ron Eddy (Brant-Haldimand):** Thank you for your presentation and for listing the findings. It would be my hope that every citizen would have the opportunity to read and consider those findings; very important.

Because you've stated that you fully support Bill 119, I would expect that you feel it should go further and that there would be additional items that could and should be included in the bill, perhaps even a total ban. Would you care to comment on that?

**Ms Wales:** I'm not quite sure what you mean by a total ban. Sales anywhere?

**Mr Eddy:** Banning tobacco products, making it an illegal product, rather than continuing to have it as a legal product. What other features do you think should be included in the bill?

**Ms Wales:** I've listed the ones that I feel we can really stand there and support, and those are finding ways to decrease access for young people and also making it so that non-smokers are not exposed to smoke they do not choose to be.

One of the issues for people we see, who are extremely environmentally sensitive—they may very well be like the canaries in the mine, telling the rest of us things are happening—is that even being around someone who has smoke on their clothing, going into an establishment where there may not be smoking but which smokers frequent, is an exposure to environmental smoke. Some of the research studies recently have shown that the smoke that lingers as a smell in clothing and in furniture is actually the most toxic part of the side-stream smoke, because it has remained there and is gassing off slowly.

Those would be our biggest concerns. I think we have to work with all of society to find solutions that are not just going to drive things underground, but are going to find a way to really tackle this problem and increase our ability to have healthy people in our society.

**Mr Eddy:** Thank you for your information.

**The Chair:** Thank you very much for coming before the committee today and for your presentation.

RICHARD STEIN

**Mr Richard Stein:** Thank you very much for inviting me. I don't have a presentation. What I'd like to do is share my experience of the last 30 years since I've graduated.

Richard Stein is the owner of what we call the Medicine Shoppe. The Medicine Shoppe is an independent—and I stress independent—pharmacy, a very small pharmacy located in the west part of Toronto. We're in a

medical building. I bought my store in 1974.

The store never sold cigarettes, so that wasn't really an issue. I thought about it for maybe five or 10 seconds and I knew I wasn't going to sell cigarettes, although all my competitors did. But I knew I had to find other areas to make the pharmacy viable and profitable. That's what I'd like to share with the committee this morning—this afternoon, tonight, whatever. Am I not nervous? I'm nervous.

I must say I stress independence, because I'm an independent pharmacy. I've always gone my own way. Just recently, the Medicine Shoppe is now a national franchise and you'll see many Medicine Shoppes, I hope, across the country. It would be my biggest pleasure to go head to head with Shoppers Drug Mart. Although very small, I believe we're very professional. I must say, now that the Shoppers Drug Mart pharmacists have left, I can really talk quite freely.

I was fortunate that my location in the west of Toronto was right on Bloor Street and in a medical building. We're in the corner of a medical building. At that time, 20 years ago, most of the doctors did smoke and they asked me frequently, "Would you please get me," or, "Could I buy?" I constantly refused to sell them.

I needed to find other profit centres, other niche markets that I could sell as a pharmacist. For the next several years, I concentrated on expanding the area of home health care items, creating departments such as durable medical equipment with wheelchairs, canes, commodes. We went into ostomy supplies; orthopaedic supplies, which includes sports, medicine braces, back braces, shoulder braces and so on; surgical stockings and compression therapy for those people who are suffering from lymphedema and varicose veins.

We went into mastectomy forms and breast prostheses for women suffering from breast cancer. This required a major commitment on my part and my wife's part, who was involved in the surgical fittings and the breast prostheses, a major commitment in resources and financial commitment, and in time and energy spent at various conferences, seminars and schools, and this continues on today.

We have two consultation rooms. As Mr Phillips mentioned, he counsels his patients on the medications. We counsel our patients not only on the medications, but on their medical fittings and their surgical supplies.

What of the future? I'm very positive. Everybody's crying the blues. I haven't yet had the need to do that. I've just returned from a seminar in the States on specialty compounding. This is not my brochure, but I will have one like it in a short time. Prior to 1950, compounding was very prevalent in pharmacies. The doctors would not write for brand X, they would give you several chemicals and ask us to compound them in. It's come full circle. Pharmacists who are doing very well in the United States profitably are compounding chemicals. They're meeting patients' needs and this is what I propose to do.

Also, our pharmacy will set up one of the first, if not the first, pain clinics. We're going to have a pain treatment clinic with the use of magnetic devices and electro-

magnetic modalities to treat pain. This will be under the supervision of a trained physiotherapist or a kinesiologist. We're also developing a lymphedema treatment clinic. Under my direction, the same person will use pneumatic compression devices to treat those patients with lymphedema.

Compounding customized medication, as I mentioned: These are some of the devices that we can compound. These are all blanks, but we will ask the physician what he would like us to put into them.

We're also developing a book- and video-lending library, because we're moving away from the product and towards information. Providing information will be the pharmacist's key role in the future.

I've practised pharmacy since 1963 and I've enjoyed every minute of it. I am proud to be a pharmacist. I'm proud to meet my patients' needs not only pharmaceutically but in other areas. I support Bill 119 and I commend the committee for hearing me.

I have a little placard that I put up in my store. Because we don't sell cigarettes, I thought, why not say so to my patients? I'll read this to you, "Although cigarettes provide some pharmacies with healthy profits, we decided years ago we'd rather have healthy customers."

Just to show you, the medical fitting department is more than 50% of my total sales volume; pharmacists can reach out into different areas and develop many profit centres for their patients' needs.

Thank you for your time and I'd be happy to answer any questions. If I don't know the answers, I'll take your phone number.

**1630**

**Mr Jim Wilson:** Thank you for your presentation. On the issue of the ban of tobacco sales in pharmacies, obviously you're expanding and have expanded your pharmacy into some very interesting areas and I think you're going to hit a good niche mark.

The compounding market: I know what you mean. In the United States it's a growing market and people probably long for the day when the pharmacist is actually a chemist again. I wish you all the best.

**Mr Stein:** Thank you very much.

**Mr Jim Wilson:** In the prosthesis department, I just had a first cousin Patrick O'Leary go bankrupt on that one, because in a small town like Tottenham, two in town is one too many. Not everyone can get in it, or certainly there's a limited market there.

**Mr Stein:** There's a limited market there, and that's why I could not make it in any one market. You need a broad base and that's why I developed all those niches. We're fortunate that my wife's breast prosthesis business is very good, but we're in a large centre. In a small town, it wouldn't work. They'd have to take on ancillary services to provide.

**Mr Jim Wilson:** I think that's the worry, though, of some of these pharmacists. In many of the smaller towns in Ontario and the towns I represent, there might be two or three pharmacists, or four now I think now in the case



of Alliston, which has a population of only 6,800 people but has a large rural area around it.

Those who are selling tobacco feel it's one of the reasons they're still in business, because it's enabling them to compete on the retail side with other retailers down the street who are selling tobacco. They simply feel that if the government were to remove their ability to sell that product, it may be the last straw.

**Mr Stein:** I feel very strongly that they can turn that around full circle by being a total health care provider and offering information on health care. Our phone rings off the hook, because people don't know where to turn. They call us. We don't sell tobacco, but we don't have to sell tobacco. I don't even want to sell tobacco. I want to sell health care items and I stress that very strongly. They come to us for health care items and I make it. That's why I have my little sign. People go across the street to buy their tobacco and they come to us for their health care items, because we're perceived as being a health care store.

No doubt that's what they'll likely have to do. So far, my sense of these hearings is that the government is not budgeting very much on this particular provision. You may want to start consulting, telling them how to get into various niche markets, but the fact of the matter is that I think some of them are going to go out of business through no fault of their own.

**Mr Stein:** But they don't have to. There are so many areas out there, if they'd just open their eyes. There are so many areas out there, even with four stores in town, that don't sell tobacco. People are going to go to other food stores to buy their tobacco. There are other areas in the health care industry that people are literally dying to find information on, to find the products and to find the services. I think that's what we as pharmacists have to capitalize on.

**Mr Martin:** I also want to thank you for coming forward. I find your presentation rather refreshing and enlightening, because as I listen to the presentations that come forward, particularly on this piece of the legislation, I sometimes find it quite confusing. You've clarified a few things for me this afternoon, and that's the question of whether pharmacies are in the health business or in the retail business in a different way.

We certainly today had a number of the retailers come forward to talk to us about the impact of this legislation on their operations. It seems to me that maybe some of the problem they're presenting here and suggesting that we are somehow compounding for them is actually something they brought on themselves by moving over the years away from the very professional, sophisticated business of pharmacy you're explaining and describing here today to actually simply being distributors of a product and then a million other things.

There's a complaint right now that the way pharmacists are being paid by the government, for example, is by the number of pills they dispense. They become dispensers as opposed to the kinds of other things that they could get into actually, in fact in partnership with us. There's some suggestion to the government by folks like yourself that the very valuable counselling you do as a

pharmacist should be worth some value to the government and should be paid for so that pharmacies could return a bit more even than what they've traditionally done over the years.

I suggested this morning that maybe where the pharmacies are in this instance saying that we're creating an unlevel playing field by taking away from them the ability to sell cigarettes, they have a non-level playing field in that they have a monopoly re the dispensing of pharmacy products and all the other things that they can do.

The answer that came back was, "Anybody could become a pharmacy." I suggested that maybe we should allow corner stores to get into the pharmacy business. The suggestion that came back was: "Okay, that's fine. That could happen." I felt that was a rather facile, simple response to a question that maybe was a bit more difficult than that. Could you respond to that?

**Mr Stein:** Pharmacists will be going down for the third time and they're just going to be grasping at straws, but they don't really have to, if they take a look at their patients' health care needs, tobacco not being one of them, and just begin to satisfy one or two of those needs, and then one or two of those needs later on, and another one, and then keep adding. That's all I did: one step at a time.

**Mr Martin:** What you're telling me is pharmacy is a very specialized area, and if it is developed further—

**Mr Stein:** Pharmacy is a wonderful venue for expanding as a total health care provider in the way of product services, in the way of medical fittings, surgical stockings, product information, special compounding. Pharmacy is, I feel, the very best of all the medical professions to provide the kind of services we have at our disposal.

I think those few pharmacists who are really keen and lose their tobacco, are forced out of it, should look to other areas in the health care fields and start providing some of those services. They don't have to be run by the government. They don't have to be ADP, the assistive devices programs. They can be for cash, Visa or cheque, across-the-counter sales of health-related items. That will more than make up. I'm just speaking from my own experience.

**The Chair:** Thank you very much for coming before the committee today and for your presentation. We appreciate it.

#### COUNCIL FOR A TOBACCO-FREE YORK REGION

**The Chair:** I call on the representatives for the Council for a Tobacco-Free York Region. We want to welcome you to the committee. The parliamentary assistant and I both have to declare a conflict of interest, as we're delighted to see people from York region. It's great to have you here. Perhaps you could introduce yourselves and then just organize your presentation however you think best.

**Ms Joanne Kaashoek:** Good afternoon. My name's Joanne Kaashoek. I'm the chair of the Council for a Tobacco-Free York Region.

**Ms Tania Gabrielle:** I'm Tania Gabrielle.



**Ms Linda Pugilese:** I'm Linda Pugilese. We attend Father Bressani Catholic High School in Woodbridge.

**Mr Fady Samaha:** I'm Fady Samaha.

**Mr Frank Casicaro:** I'm Frank Casicaro. We attend Sacred Heart Catholic High School in Newmarket.

**Ms Kaashoek:** The Council for a Tobacco-Free York Region is a coalition of community members and health agencies that work together to reduce and eliminate tobacco use in York region. Our mandate is to support non-smokers in securing smoke-free environments, but at the same time we engage in educational campaigns which raise community awareness about tobacco use issues.

First, we would like to offer our support to the Ontario Tobacco Control Act and commend the NDP government for introducing this legislation which protects the health and wellbeing of young people in our communities. We also commend those opposition members who support Bill 119.

At the same time, we're very concerned about the fact that some opposition members are criticizing aspects of the bill such as the pharmacy ban and the vending machine ban. Protecting the health of youth today and tomorrow should be a non-partisan matter. It is unfortunate that the opposition parties are attacking this excellent piece of legislation.

If Bill 119 is implemented, it will have a vast impact on the health of future generations of youth in York region, based on our population analysis, which is included within this report.

We are aware that tobacco is the worst health epidemic in history. In York region alone, 400 men and women aged 35 and over have died prematurely in 1990 from smoking-related causes. This number is conservative, as it does not include neonatal deaths, miscarriages, deaths from passive smoking or data from past smokers.

**1640**

In 1990, approximately 50,000 people aged 20 and over in York region were smokers.

York region youth have a great deal to say about how many youths smoke in their schools and how easy it is for them to gain access to tobacco products.

I will now turn the presentation over to Linda Pugliese and Tania Gabrielle.

**Ms Gabrielle:** Linda and I are part of our school's student wellness council. We took a survey within our school to find out how many students smoke. After surveying 1,122 students, we found that 20% of the students smoke. However, we believe the percentage to be much higher because it seems that almost everyone smokes in our school. Of those 20% who admitted to smoking, 50% started between the ages of 14 and 16, and 48% of those people said they would like to quit.

**Ms Pugilese:** Our school's wellness council also went to local stores and gas stations within the community, and we were able to purchase cigarettes from nine out of the 10 stores, even though we are under age. This made us realize how accessible cigarettes are to teenagers.

I personally believe that many teenagers begin smoking because they're pressured into it by their friends, to raise

their self-esteem, or simply because they have nothing better to do. It doesn't help that cigarettes are so accessible to teenagers. Teenagers do not stop to think about the long-term effect smoking will have on their lives. I believe that Bill 119 will help to reduce teenagers' accessibility to cigarettes and hopefully make them think twice about smoking.

I'll now turn the presentation over to Frank and Fady.

**Mr Casicaro:** We both attend Sacred Heart, as you know, and we felt that there was a major smoking problem in our school, because in our school we have a designated smoking section behind the school and we noticed there were a lot of teenagers who smoked.

Grades 9 and 10 usually were the most populated, so we felt there was a need to start up a support group at our school for students who are interested in quitting smoking. We both feel that the smoking section in our school is a bad idea, considering that we're trying to help students quit smoking. We felt that if we started up a non-smoking program, then we could help students, at least at our school, quit.

Fady and I did a survey at our school to see exactly how many people smoke and how many cigarettes they smoke a day.

**Mr Samaha:** The people we surveyed were between grades 9 and 11. We surveyed some grade 12s and 13s, but it was basically 9 to 11.

Out of 313 students surveyed, we found that 23% are smokers and 77% aren't. Out of the 23% who smoke, 75% of them smoke one to 10 cigarettes per day and 25% smoke more. Out of the people interested in quitting, there were 56% interested and 44% not, and for the people interested in the program, there were 39% interested and 61% not.

This might not seem like a lot of kids that are smoking, but it is. If you go out there and you see these kids, they're wasting their life on the cigarette, and it's so easy to get cigarettes now. You don't have to buy a pack anymore. You can just go into stores and buy a cigarette for 25 cents, and that's what's happening. They don't get ID from you or anything; you just walk into any store.

We were in Toronto, before we came here, near the Eaton Centre, and we walked into a couple of stores. We'd just go in there, "Can we get a pack of cigarettes?" and nobody would say to you, "Listen, let me see some ID." They just say, "Okay," and that shouldn't be happening. That's why a ban should be done.

We believe that if the stores that sell cigarettes got licences, it would be better. Then they'd think twice before selling to teenagers, because if these stores get caught selling to people under 18, their licence may be revoked. That will make them think twice. That's why we believe, if Bill 119 was passed, then there would be less youths using this deadly drug and hopefully no youth at all.

**Ms Kaashoek:** Thanks, Frank and Fady. I want to just outline some of the provisions that we're very much in support of, and then add some recommendations in terms of how we believe Bill 119 can be strengthened.

We are very much in support of those provisions

which increase controls on tobacco sales to minors and those provisions that reduce tobacco outlets through the ban of cigarette sales in vending machines and in pharmacies. We're very much in favour of banning cigarette sales by health care professionals, and especially in pharmacies, to remove the contradiction of providing health and also providing illness. We're very much in favour of improving packaging controls and provincial health warnings and prohibiting smoking in designated public places. We're also very interested in strengthening the non-compliance penalties.

I want to draw your attention to page 7, which describes in more detail how Bill 119 can help the Council for a Tobacco-Free York Region deal with some of the issues and concerns that we have ongoing in our region right now. I won't dwell on that. I want to move ahead to the recommendations section because it's very important.

Even though the provisions in Bill 119 are very good, we have concerns with certain aspects of the bill. If we as health professionals and politicians are really serious about protecting our youth from tobacco addiction, we need to provide consistent individual and societal messages about the addictive properties and ill-health effects of tobacco products. Educational messages about tobacco will never be effective without strong social legislation that supports the rights of non-smokers and restricts tobacco sales to youth.

Young people are especially aware of inconsistencies in messages that tell them not to smoke. Smoking is still allowed in most public spaces and workplaces in York region. Cigarettes, prominently displayed through exciting sponsorships and attractive packaging, are readily available to youth under the age of 18 either in kiddie packs or even in single cigarettes. The message to youth is that smoking must not be that bad for you because it is so visible in our society and it is part of the lives of so many adults.

Our first recommendation is that, if we want to really enforce and make sure that tobacco is not sold to minors, we need to develop a licensing system for tobacco retailers. Tobacco retailers need some type of incentive that is going to deter them from selling to minors. Two recent studies in the USA confirm this by showing that education alone was not effective in reducing retailer sales to minors. Only after an effective licensing and enforcement strategy was introduced did sales decline from 70% to less than 5%. That is significant and should not be overlooked.

The need for a strong Bill 119 is greater than ever in the face of the federal government's proposed tax rollbacks. The Council for a Tobacco-Free York Region believes that a tax rollback would do very little to deal with the smuggling issue and it would only add to the tobacco industry's sizeable profits, to the detriment of the health of thousands of children and adults. A licensing system of tobacco retailers would help all governments, municipal, provincial and federal, deal with the smuggling crisis.

1650

Our second recommendation is that we need to provide

a more consistent message to young people and adults about smoking and secondhand smoke and their harmful effects, and we can do that by banning smoking in all workplaces.

We get a lot of calls from people in York region who work in workplaces that have no controls at all in terms of banning smoking. They call us and tell us about how difficult it is for them to work in these environments. They ask what recourse they have. Their recourse is a long, laborious procedure because there are nine different municipalities in York region, each with a different non-smoking bylaw. It's important to provide a strong minimum standard against—is my time up?

**The Chair:** It's okay. I just know there are some questions.

**Ms Kaashoek:** As cigarette smoke and secondhand smoke are classified as a class A carcinogen containing more than 4,000 toxic chemicals, there should be no further hesitation in banning the substance from work sites.

Briefly, I want to just say that our council is very interested in supporting the provisions in Bill 119. In the fall we're hoping to do an education campaign around some of the provisions in terms of targeting retailers and informing them of the law and their duty not to sell to minors, and we believe that a strengthened Bill 119 could help us make this educational campaign more effective.

In conclusion, I just want to say that the speedy passage of this legislation would very much help the Council for a Tobacco-Free York Region in securing a smoke-free York region.

**The Chair:** Thank you, and we also had the full brief to read, but I know there are some questions and I just want to make sure we have some time for that. We'll begin with the parliamentary assistant.

**Mr O'Connor:** Both members from York region sitting here would like to ask you some questions. The Chair isn't allowed to and has graciously allowed me, but usually I'm on the receiving end of questions.

I want to talk to the young people here because I really appreciate your coming to the committee. Of course the legislation is geared for young people, trying to keep young people from starting the habit of smoking.

In the legislation, again, is the vending machine ban. Licensed premises, which are restaurants and taverns and what not that sell alcoholic beverages, which you can't consume of course until you're of the age of majority, have vending machines in them. We heard that the federal legislation doesn't include a total ban like ours does but excludes it to that.

As a young person, do you feel that you could go into a licensed premise, go to a vending machine and purchase cigarettes without somebody saying, "Hey, what are you doing?" That's one of the areas that we're trying to focus on as part of the legislation as well as a number of other areas. I just wonder if you want to comment on the vending machine element.

**Mr Samaha:** We can. If you want to buy cigarettes from a vending machine, nobody's going to stop you. When me and my friends go out—there are some who



smoke—there are vending machines in doughnut shops too and you just go up to them and you ask the lady for change, she gives you the change and you go buy it. Nobody's saying anything. They just want to make a profit. They're not going to ask you for identification or anything.

**Ms Gabrielle:** Also, my father used to smoke and if there was ever a time he needed cigarettes, if we were in a restaurant he'd give me money, I'd go to the vending machine and get him cigarettes. Nobody would stop me. This was even before; I was 13 or 14, I would just go up, get some change and go get them. Nobody would say anything.

**Mr O'Connor:** That would be a licensed premise.

**Mr Jim Wilson:** Thank you for your presentation. I think you did an excellent job. My party, the Progressive Conservative Party, agrees with most of what you've said and we're interested in looking at some sort of licensing provisions.

Two things were pointed out, though. One is that the opposition parties have a little problem with the vending machine thing. I think we should just explain we don't have any problem with banning vending machines; we just think if the government takes away something, takes away part of your business, it should compensate you. We don't think that's a big thing. That's the official stance of my party on it.

The second one is with respect to pharmacies. When the government had its press conference to announce this legislation, the minister herself announced to all of the press gallery, all the people and the reporters, when they said, "Do you have any proof at all that banning the sale of tobacco products in pharmacies will in any way stop young people from smoking or reduce the chance that they'll start smoking?" she said, "No, we don't have any proof. We just think it might." There have been a lot of people coming towards us saying, "We don't see how that will because they'll just go down the other end of the mall and buy them at the smoke shop or whatever."

We've been saying things like maybe we should make it illegal, like we do for alcohol, for young people under the age of 19 to smoke. You can't drink so why in the world do we let you smoke? The current model—and this law just makes the current model one year older; it's 18 now and then it goes to 19—puts all the blame on the grocery store clerk or the owner of the pharmacy, whoever sells you the cigarettes, and we think that young people should take some responsibility. After all, we're going to charge little kids with not wearing their bicycle helmets and we charge people all the time with drinking under age or having open alcohol in their possession under age. So that's one thing we're thinking of.

I don't want you to get the impression that the opposition people are bad people. Part of our job is to—

*Interjection.*

**Mr Jim Wilson:** No, I saw that, because a lot of you wouldn't make eye contact, and I thought they must think we're really bad, but we're not. Part of our job in a parliamentary democracy is to point out flaws, and when we aren't totally convinced on something, there's a whole

pile of other people out there who want to have their views brought forward, so we try to help them do that.

I will ask you a specific question about pharmacies. Fady, you mentioned that you can get cigarettes at pretty well any store and nobody ever asks for ID. It seems to me that if the government really wants to control the sale of this product, who would you trust more, the Becker store clerk or the pharmacist, to check for ID? Which leads to, maybe we should move all the cigarettes into the pharmacy and take them out of all the other stores. After all, that's where all the other poisons are kept.

That's what we've been saying, so if it's confusing I'm sorry.

**Mr Casicaro:** Pharmacies may tend to ask the person for ID more than maybe a corner Becker store or whatever but there are some pharmacies that will not ask for ID when students walk in and buy cigarettes.

One thing to do is probably ban the sale of cigarettes from pharmacies, but that may also have the students go to smoke shops on the corner or whatever. Like he mentioned earlier, maybe if there was a licence put in; if you walk into a liquor store and a minor purchases a bottle of liquor, the liquor store could get their licence revoked so they wouldn't be able to sell liquor any more. If a store had a licence to sell cigarettes, then that could give them the incentive not to sell to people under 18 or 19, the age limit, and they might be afraid that their licence would be revoked. That could be a key thing there.

**The Chair:** Thank you. I'm sorry our time has run out. I'm going to sneak in a quick question.

**Mrs Haslam:** Go for it.

**The Chair:** I think one of the really interesting things in your coming here is that you've done a survey with students and young people who are the people who are the object of the bill. I just wondered, would it be possible for the committee to get a copy of that? Is it in a format that we could make copies and circulate it?

**Mr Samaha:** We've got our study here so you can take copies of it. It's in a book here right now.

**The Chair:** I promise to bring it back and perhaps could drop it back to you through your office in Newmarket. The clerk will take it. Thanks very much.

On behalf of the committee I thank you all for coming in again and for the work that you've done and for sharing your views with us. We thank you.

1700

FREDERICK BASS

**The Chair:** If I could then call Dr Frederick Bass, if he would come forward. Dr Bass, welcome to the committee. It's probably fair to say you may have come farther than anyone else to present to the committee.

**Dr Frederick Bass:** When I saw in the Globe and Mail about three, four weeks ago your advertisement, and knowing that I was coming here at this very hour—in fact I arrived an hour ago—I couldn't resist calling and seeing if I could contribute, not really as a representative of the BC Medical Association but as a very interested individual.



**The Chair:** You are welcome. We're glad the flight landed. Please go ahead.

**Dr Bass:** Thank you. I appreciate the opportunity to speak. I'd like to say three sets of things. First, I'd like to make general comments about where I have seen politicians and this issue. Second, I'd like to make some specific recommendations which you may have in front of you in the form of a letter that I've written. Third, I'd like to make some brief comments about Bill 119.

As you know, BC recently finally issued the regulations for the Tobacco Sales Act after sitting on the formation of them for a year and a half.

What I'd like to say, first of all, is I think politicians really don't get it in terms of smoking. It really takes some perspective and it really takes some standing back and looking at what smoking is. For the most part, there are very few politicians I have seen who really understand what's going on.

The tobacco trade is institutionalized legal drug addiction. Tobacco is the most prevalent cause of cancer, of heart disease, of unnecessary death and of medical cost. It's the most prevalent one in Canada and it's rapidly becoming the most prevalent one in the world. Certainly, it's the most prevalent cause of mortality in the world now, including the Third World countries. Tobacco is an addiction which starts in childhood, and right now in Canada it's falling disproportionately on people who are uneducated and who are vulnerable.

I really haven't had to function from your perspective, but from my perspective the way politicians usually work is to compromise. They hear a range of views and they find some ground that hopefully makes the fewest people angry and sometimes the most people happy.

When you compromise with the tobacco industry or with people who are selling tobacco, you are compromising the brains of children. You are compromising the brains of children with respect to starting them on the road to addiction.

A 13-year-old kid is so remote from heart disease, lung cancer etc that it's meaningless, but every day that this 13-year-old smokes, she or he is digging himself or herself a little deeper into nicotine addiction. There is a nice—I don't know if it's nice, but there is a prospective study in California that shows that between the ages of 11 and 14, the cohort of girls that they were following were addicting themselves. Of course, you're not only compromising the brains; you're compromising the lungs. School children get more lung disease when they're exposed to cigarette smoke, and ultimately their hearts.

The third introductory thing I want to say is that for 90% of smokers, their addiction is really a form of slavery. That sounds exaggerated, but I'll tell you that only 10% of smokers smoke fewer than five cigarettes a day, and if they really could take it or leave it, many more would be smoking five cigarettes a day. It is not that way with alcohol.

Canada produced an extraordinary study after the 1988 Surgeon General's report called Tobacco, Nicotine and Addiction. When the Royal Society of Canada was asked to choose between the terms "addiction," "dependence"

and "habituation," they came down very clearly on the side of addiction even though—

**The Chair:** Sorry. Just on that study, is that from the federal Department of Health and Welfare?

**Dr Bass:** No. Perrin Beatty, Minister of National Health and Welfare, and the Department of Health and Welfare commissioned the Royal Society.

**The Chair:** The Royal Society?

**Dr Bass:** Right. The Royal Society of Canada. I certainly would recommend you look at it, because they make this comparison between the proportion of smokers who have to use the substance on a daily basis versus the proportion of alcohol users who have to use it on a daily basis.

The other thing is that only one third of smokers do not smoke 365 days a year when you go out in the population and ask them, find out how long they've been off. This is a highly addictive substance.

What this committee does is going to determine whether the corner store still stays in the business of addicting kids. It's that simple. If you seek to compromise and get some middle ground among all the people who are going to sit at this table and talk to you, I doubt that you'll pick the best long-term solution. It'll take a lot of courage to pick the best long-term solution.

I'd like to just go through the letter that I wrote. I am chair of the tobacco and illness committee of the British Columbia Medical Association. I direct a project which helps all the interested physicians that we can recruit in BC to help their patients stop smoking, and it now represents 400 physicians, 13% of the GPs in the province.

I just want to quickly touch on the recommendations. The bottom line here, I think every one of you will agree, is whether kids, children, continue smoking and continue easy access to tobacco.

Therefore, my first recommendation is that you track what happens so that you have an annual report that looks at what is the prevalence of underage smoking, where do kids get their cigarettes and what proportion of corner stores are selling to kids.

Second, the previous party mentioned the data from Woodridge, Illinois. It's in the Journal of the American Medical Association and it has been circulated to you. There is a gentleman there who should be in this room. He came to Victoria. His name is Sergeant Bruce Talbot and he can tell you, very clearly in no uncertain terms, why education and a voluntary approach did not work. He has no axe to grind. He just has his experience. The coincidence there was that there was a sociologist who was actually studying the subject of buying at stores as he was getting interested in it, and were it not for that coincidence, we wouldn't have the kind of information that Sergeant Talbot is able to provide.

The third point is, it's fine to pass a law but, for goodness' sake, whatever you decide to do, put some money into making it happen. It's so easy to pass a law and not put the dollars. This is a tremendous investment. The dollar costs of medical care that come from smoking are underestimated. I know about this. I did a doctoral

thesis at Johns Hopkins after I got my MD on this very subject.

The fourth, and this I think is going to seem unpalatable to a lot of you, is that you have to provide for sting operations. How in the world is an inspector going to walk into a store and know if it sells to children? What they do in Woodridge, Illinois, is the police deputize 13-year-olds and that's the way they find out, and they do it on a regular basis.

They know that the baseline study was at 83% of vendors were selling to underage kids. They know that after the first volunteer vendor education program went in, it went up to 93%. They know that after the first warning that vendors got, it actually dropped only to 33%, and they know that after they closed down the stores just for one day and pulled the licences, after all these other things were tried, the next time they looked at the frequency of stores selling to kids, it was 0%, and three months later it was 0%. So you need to do sting operations. If you're concerned about underage kids buying cigarettes, there's no other way to find out. I wish there was a nicer word than "sting."

1710

Fifth, one of the things they also did in Woodridge, and I think Mr Wilson has just referred to it in a more exaggerated way, is that they are able to ticket any youngster who is in possession of tobacco, and the ticket goes to the parents. I recommended here that anyone who's duly trained and has the authority have the authority and obligation to confiscate tobacco a youngster has. Again, a ticket for possession.

With respect to your bill, section 6, I think the warning should be about what the warning to kids should be about, and that is not just health but addiction.

Section 12, aboriginals: You know, the cigarette is a white man's invention. It was introduced to the world in 1876 at the World's Fair. Natives did not use cigarettes. How many people in this room have ever seen a native ceremony involving tobacco? Several of you have. Four of you have.

I think I would speak for native use of tobacco in the traditional native way, and I wonder if you might invite some native elders to at least appear before the committee so as to arrive at a better definition, to arrive at a clear definition, of what native traditional use of tobacco is, because I'll tell you, cigarettes are not traditional native use of tobacco.

By the way, you should note that a cigarette functions, because of the physiology, as one of the most addicting forms of intake of tobacco—not one of, the most addicting form—because basically what happens when you inhale cigarette smoke is that you dump it into the arterial tree. It's even worse than injecting it into a vein in the arm. It gets to the brain right away.

So cigarettes are a very powerful, very negative form of tobacco use. Native traditional use is a much more elegant form, and I would urge you to get consultation about that, and also to seek definition. To me, this is a licence for native hustlers to hustle. I would fully support the wording of this to recognize truly native traditional

use. I thought it was excellent seeing these youngsters here. I would urge you to speak to non-smoking youngsters who are adventurous enough to go into a store and try to purchase tobacco. Have you had any, or do you plan to have any, of that kind of testimony?

**The Chair:** We've had the students who are here, but it's they who have requested to come before the committee.

**Mr O'Connor:** We actually had a presentation yesterday from Halton region, I believe, where they had undertaken sting operations. The minister's position on sting operations, though, is that the minister doesn't want to conduct sting operations with people who are under the age of 19, but maybe people who are over the age of 19 who appear to be under the age of 19. But it has been documented and we've actually had presentations to the committee by people.

**Dr Bass:** This girl, aged 13, who made the front page of the Province—the headline is: "Dead Easy: It's Like Helping Kids Commit Suicide, Says Young Cigarette Buyer"—appeared before the Legislative Assembly committee, the select committee, and I think the testimony of a youngster who isn't a smoker would be really very informative for you.

I would like to congratulate you on including pharmacies in the designated places. We don't have any randomized control trials. Some things you do, you just have limited evidence on, but I think—and this is my feeling; there is no hard evidence on this—that children, when they see cigarettes and candies sold in a pharmacy, are getting the wrong message. I think that if the pharmacy is going to be part of the health care system, it shouldn't be selling the number one preventable cause of death.

**Mr Eddy:** Dr Bass, thank you for taking the time to appear before us and making the presentation, especially for suggestions to improve Bill 119. I notice in talking about the best long-term solution to tobacco control, however, you did not mention anything about a ban of tobacco products or making tobacco indeed illegal. Realizing, and you may be aware, that there is a very large underground economy in contraband cigarettes, especially in this province, completely out of control—you may be aware of that—what do you think of a ban now or in the future some time?

**Dr Bass:** I would not be for a ban. I think it's impractical. But I would be for something that Ontario shied away from. I was very excited about your considering sale only in provincial stores. The number of people buried via tobacco is four times that buried via alcohol, and we have provincial stores in BC for alcohol but not for tobacco. We don't even know how many vendors there are in BC for the most addictive and lethal product around. So that would be the direction, I would think, to go. Put it in a provincial store.

**The Chair:** Dr Bass, I regret that we're at the end of the day and I'm afraid we still have several presenters, but I do want to thank you very much for coming, as I said at the beginning, from so far away. For the documentation, I wonder if before you leave the clerk might just be able to make a copy of that one article you



showed, the one you had of the student.

**Dr Bass:** Oh, the student. Okay, sure.

**Mrs Haslam:** Mr Chair, I would like clarification here. Remember when I talked about 3,000 adolescents become new smokers daily and everyone said no, it was a month. This article says it's 3,000 adolescents become new smokers daily. Is that in the States compared to 3,000 a month in Canada? Are you aware of the discrepancies in this information?

**Dr Bass:** Well, the States is always 10 times what Canada is. That's my formula, and it works usually.

**Mrs Haslam:** This documents says what I said, 3,000 adolescents daily start smoking.

**The Chair:** That's something perhaps we could ask Bob to check out.

**Mrs Haslam:** Thank you. That's fine. I just noticed that, and I was called up on it.

**Dr Bass:** May I just say one thing to Mr Eddy? Please, if you're interested in smuggling, look at the cancer society—an excellent report. The recommendations in this report are not discussed in the media.

**Mr Jim Wilson:** That's the most recent one?

**Dr Bass:** Yes. This is January 1994.

**The Chair:** I was just going to say with that we have had a number of the cancer divisions in Ontario and we will be having a submission from the Canadian Cancer Society. I suspect they will bring that forward.

**Dr Bass:** One of their recommendations is to encourage provincial licensing in order to do something about smuggling. Certainly, if you went to a provincial store, that would be the ultimate in terms of controlling the flow of tobacco—cigarettes.

**The Chair:** Again, thank you very much for coming before the committee. We'll return that clipping momentarily.

CARMEN PAQUIN

**The Chair:** If I could then call on Ms Carmen Paquin, I'm sorry we're running a little bit late, but we welcome you and look forward to your presentation.

**Ms Carmen Paquin:** Thank you. Good afternoon to Mr Chairperson and Mr Arnott and the committee people as well. My presentation is very short.

We do not debate whether cigarette smoking is harmful to the smoker or whether secondhand smoke affects non-smokers. The problems arise when the smokers smoke in areas where others are affected, primarily anywhere in an indoor area. Since we spend 92% of our time indoors, the air that we breathe becomes very important.

Since voluntary policies do not work, it becomes necessary for government to make legislation that will work. It is difficult for me to accept that provinces have not come up with satisfactory solutions when the federal government has done so, and I speak primarily of the no-smoking policies in the federal bill called the Non-smokers' Health Act, which prohibits smoking in any federal building or on federal property, a policy which has been in effect since January 1988 and is 100% successful. Smoking should not be permitted at any time

or in any place, whether it is a workplace or a public area. There should be no designated smoking area.

1720

Because children and teenagers are not sufficiently informed about the dangers of smoking, they cannot make an intelligent decision whether to smoke or not. Restricting tobacco product purchases by raising the age to 19 is a step in the right direction and will help in the ongoing process to educate children, teenagers and adults to the harmful effects of tobacco products.

Removing the sale of tobacco products from such places as hospitals and medical buildings, psychiatric facilities, nursing homes and pharmacies, especially pharmacies located inside hospitals and medical buildings, is absolutely necessary. The above establishments which continue to sell tobacco products should consider no longer referring to themselves as health care professionals, because that is a contradiction.

I know of two pharmacies that have chosen to not sell cigarettes and have suffered no financial disadvantages. One has never sold cigarettes in 20 years and the other has replaced that area formerly occupied by cigarettes with natural health care products.

I am making a presentation today because I know that tobacco products kill. I will work to help the government make changes through public education, community programs and legislation, all of which are necessary to prevent people from starting to smoke, for helping smokers to quit and to protect people and animals from harmful effects of secondhand smoke. I would like to thank and support the Honourable Ruth Grier, the Ontario Minister of Health, for presenting a strong piece of legislation.

**Mr Wessenger:** Thank you for your presentation. You indicate you'd like to see the restrictions in smoking in public places strengthened. By "public places," do you mean interior space? You basically mean interior, not outdoor, space.

**Ms Paquin:** Yes, shopping malls and those kinds of places where I feel I don't have a choice when I go in there, so I choose to not go to such places.

**Mr Wessenger:** Fine, thank you.

**Ms Paquin:** I have a couple of comments, if I may. Is this being recorded?

**The Chair:** Yes, it is.

**Mr Jim Wilson:** It will be repeated tonight too, so you can go home and watch it.

**Ms Paquin:** Really? No, I'm not going to do that.

**Mr Jim Wilson:** I just have a question because I really haven't had a chance to ask it before, I don't think. There's the prohibition banning the selling of cigarettes and smoking, I guess, in psychiatric facilities. We did get a petition from Penetanguishene Mental Health Centre, from the residents' council. Actually, I think it's a council that is an advocacy council for residents; it's non-residents who are advocating for the residents inside. There were quite a few names on it, saying that it just really added stress to their lives.

We do know that there's a higher percentage of



psychiatric patients who smoke than the rest of the population. Have you given any thought to that? I'll have to dig it out, but they claim that it would add more stress to their already stressful lives if they couldn't smoke, and I think it has put the government in a bit of a predicament. I don't think we're quite sure what to do with it.

**The Chair:** Before she answers, did you say that you understood that they cannot smoke in psychiatric institutions today? Because I thought in fact they could.

**Mr Jim Wilson:** No, they can in designated areas. Under this new act, they won't be able to buy any, and they can't go out to buy them. I'm not sure, in terms of being prohibited to smoke, whether or not—because we don't know what the regulations are—they'll even be able to smoke there.

**Ms Paquin:** The first point is that nicotine is not a stress reducer, so for them to not be able to smoke would not be an increase in stress; it would be a reduction. Every 30 minutes, when they believe they would like to have a cigarette to lower their stress levels, they're fooling themselves; they're increasing their stress level.

The other thing is it's just plain and simply blackmail. That's what that is. What about the health care workers who have to be inside that room, along with alcohol counselling or whatever? They themselves are being exposed to a group of 20 or 30 or 40 people who say they cannot go an hour for their counselling without smoking, and those people who are the health care workers have no choice. They should have a choice.

**The Chair:** Thank you. You said you wished to add something?

**Ms Paquin:** Yes, I was listening to Dr Bass, I think his name is. I know this subject very well. One of the things they have discovered is that it takes as little as three cigarettes for a child to become addicted. They say that if a child is around the age of 10, he or she can smoke three cigarettes, or over a period of three months several packages of cigarettes, and they are addicted for life. So I think it is important to raise that point.

I was involved federally with no smoking on airplanes and I was a principal player in that. If people can go 12 hours without smoking on an airplane, there is no reason on this earth why they cannot work eight hours in an office without smoking. I very seriously present that to you. I know it; I'm there. I'm a flight attendant with Air Canada, and we have a huge success. I say to you, if we can do it, anybody else can do it.

**The Chair:** Thank you very much for coming before the committee today.

UNIVERSITY OF TORONTO,  
FACULTY OF PHARMACY, CLASS OF 1994

**The Chair:** I call on our last presenter, or presenters—I'm not sure—from the University of Toronto, faculty of pharmacy, class of 1994. You are all welcome to the committee. Please just introduce yourselves and go ahead with your presentation.

**Ms Mona Sabharwal:** As you said, we are the graduating class of 1994 at the faculty of pharmacy. My name is Mona Sabharwal. I'm currently the class of 1994 vice-president.

**Mr Tony Antoniou:** My name is Tony Antoniou. I'm the graduating class president.

**Ms Arima Ventin:** My name is Arima Ventin. I'm the secretary-treasurer from the 1994 council.

**Ms Sabharwal:** Again, before we begin, I'd like to thank you for your time and the opportunity to express our views regarding Bill 119. You may be wondering why, as students, we are interested in speaking to you today on Bill 119. I'll just explain that to you.

I'm sure you've had many pharmacy groups come and speak to you regarding this issue. We all feel that as future practitioners we offer a different perspective. As students we do support Bill 119 in its efforts to remove tobacco from pharmacies as well as recognizing pharmacy as a health care facility.

We'd like to present three main ideas that we feel are central to the issues around Bill 119. Those are mainly ethical, professional and economic issues. I'd like to point out that the debate so far has really centred on economic issues, and we all feel very strongly that the debate should centre more around the professional and ethical issues.

In school what we are taught is to be health care providers. We are taught to put the health of our patients at the focus of our practice. We do this by identifying, resolving and preventing drug-related problems. Also, given the accessibility of pharmacy as a profession, we feel that pharmacists can play a key role in promoting general overall good health: diet, exercise and leading a healthy lifestyle basically. Thus, we find that selling cigarettes and tobacco products in a pharmacy setting is contradictory to the role of a health care professional.

We all know that smoking is a killer. There have been many studies that show that smoking increases the risk of serious lung diseases such as chronic obstructive pulmonary disease. It is the leading cause of preventable death in Canada. This is undebatable. We feel that pharmacies should be points of smoking cessation and not smoking initiation. We feel counselling on smoking cessation is worthwhile for pharmacists because studies have shown that a small, three- to five-minute conversation with many smokers can result in approximately 6% of smokers quitting smoking, and 6% of a large population can have a great impact.

As well, looking at this issue from an ethical viewpoint, the Ontario College of Pharmacists has created a code of ethics. In that code it strongly suggests that pharmacists focus the patient, again, at the centre of their practice. It also stresses that pharmacists should not knowingly provide a patient with a product that they know will harm them. This is an ethical principle that is known as non-maleficance. Again, selling tobacco products contradicts that ethical principle. It is unquestionable that nicotine and the other various chemicals found in cigarette smoke are indeed harmful to patients.

We recognize the fact that decreasing the availability of cigarettes may not stop people from smoking, but what we do realize is that it may prevent people from starting. We also realize that pharmacists can play a great role in providing support and assisting patients in quitting

smoking. Again, I'd like to stress that point of smoking cessation.

**1730**

Finally, we recognize there is an economic impact of Bill 119. It affects consumers, it affects retailers, it affects government. So it affects most Ontarians. Many groups have claimed impacts such as over 300 pharmacies closing if tobacco products are removed from pharmacies. They've also claimed up to 10,000 jobs being lost. For other remaining pharmacies that are open, they predict quite a bit of downsizing.

We find some of these claims a bit questionable, simply because of the fact that cigarette sales only account for about 1.5% of average total sales. If you compare that to, say, cosmetics in a pharmacy setting, that's about 3.6%. We know many pharmacies that have successfully not sold cosmetics and are still in business, so we feel that removing tobacco sales really is not going to have that much of an economic impact on pharmacy business.

What we think we should focus on are the indirect costs of smoking and tobacco sales. We know that smoking increases the number of sick days that people need, it increases doctors' visits and it increases the number of medications people use. So it becomes a public concern when the government and employers and the public have to pay for all these services and medications that people must use. Again, it becomes a concern for pharmacy, because as a health care profession, we'd like to have a common goal with the government in reducing overall health care costs, as well as seeing a decrease in patient mortality and morbidity.

Some closing remarks: I'd like to stress that the debate by many pharmacy groups has been on the economic impact of Bill 119 and removing tobacco from pharmacies, but we'd like to move that debate to a more professional and ethical debate and not an economic one.

Again, I'd like to thank you. We'd be very open to any questions you may have.

**The Chair:** Fine. Thanks very much. There are some questions, and we'll start with Mr Wessenger.

**Mr Wessenger:** Thank you very much for your presentation. We had an earlier presentation today by a pharmacist who indicated that he had found many opportunities for pharmacy with respect to expanding its role in the health area by going into other health products. Even from a business point of view, he felt that there were enough economic opportunities for the pharmacist, so it wouldn't be an undue restriction to take away tobacco. Do you feel there are many economic opportunities for pharmacists in the health area?

**Ms Ventin:** We feel that removal of tobacco products from pharmacies shouldn't be substituted with another product. A lot of pharmacists come up with the idea that once you remove one product from the shelf, you should replace it with another one. What we feel we could do in this area is, instead of replacing it with another product, use our services. So we think we can make up for the removal of tobacco with using our services to provide smoking cessation and improving patient counselling,

increasing the areas that are used for patient counselling and speaking with patients about other matters as well.

**Mr Jim Wilson:** Thank you for your presentation. I think if the 1994 class and all of your successors come out of university with the same attitude, then we won't have any need for this particular provision that has created so much controversy in this legislation. It's always nice to see people from my own alma mater, the University of Toronto.

I think, though, when you make your presentation, you talk about the training you've had, which is modern-day pharmacy training, which is far more focused on the provision of health care, less on retail.

When someone like Larry Rosen graduated in the 1950s, and we all know Larry, he learned more about retail when he first started into pharmacy. He learned his pharmacy in school, and then apprenticing under a pharmacist, he learned a lot about retail. He and so many other pharmacists who appeared before us make no bones about the fact that it is just an economic issue for them.

In fact I thought he was extremely honest in the press conference the other day, saying, "Yes, it's an ethical dilemma." I don't think he has come to solving it in his own mind. But it's the only way that he learned pharmacy, and his pharmacies have become dependent on the retail side. In his case, he tells us there's the need to sell cigarettes to keep up with the competitors.

What do you say? I think there's hope in the future, and I assume most of your classmates have similar feelings to yourself. Is there any way we should be grandfathering people like Larry Rosen who have been in the business for 40 years and who sell cigarettes? Do we say, "Whenever you sell your business, the next pharmacist-owner who comes along can't sell cigarettes"? Anybody ever give any thought to that?

**Mr Antoniou:** I think it's important that pharmacists take a step back for a minute sometimes and rethink what they are there for. A pharmacy is not given the right to dispense drugs and to provide patients with information so that it can go and then determine what it can merchandise. A pharmacy is there first for its patients.

Regardless of when you graduated, even back in the 1950s, you were still taught to provide the best product. You may have been taught that on the job, but we are not taught how to be merchandisers. We have always been taught how to be the best possible health care providers.

I think pharmacists have to rethink what their purpose is. Their purpose is not to supply products conveniently; their purpose is to be the most knowledgeable expert on drug therapy. I think all pharmacists have to rethink that, rethink what they are there for.

**Mr Jim Wilson:** This is a point that was raised today with the so-called non-traditional pharmacies, and that is the pharmacy counter at the back of a Zellers store. I thought it was a fairly compelling presentation. The pharmacist said it would be very difficult for him to think that the customers coming in the front of the Zellers store in any way connect those products with the pharmacy department in that store. Yet under this legislation they won't be allowed to sell cigarettes in the front of the



pharmacy store. Keep in mind this is a legal product. We're not banning the sale of cigarettes, we're just banning it in one retail sector or health sector, depending on—they say they're both.

**Ms Sabharwal:** I think that's the problem that pharmacy has always had, distinguishing whether it is a retail profession or a health profession. I know today it can't really be considered as a retail profession. This is what we are taught anyway, because we're not given the skills to know how to become a good merchandiser or a good retailer.

It really is hard for many pharmacists to come to grips with that themselves. It may be easier for us because we've only had that health background. But I agree, it is very hard for someone to differentiate—for many consumers, for other professionals maybe. But I'd definitely like to stress that we think of pharmacy as a health profession and, as such, economics shouldn't really come into play for us.

**Mr Antoniou:** I think the message we want to give basically is that a pharmacist can no longer wear two hats. He or she cannot say, "At the back of my store or in whatever part of the store I am, I will provide the patient with knowledge about this and I will talk to them about their medics and I will talk to them about their condition and help them improve their lifestyle, while then at the front of the store there's promotion for a product that contradicts everything I'm attempting to do at the back of the store." I think the emphasis has to be put back on the health.

**Ms Ventin:** With regard to the issue of Zellers or a store like Loblaw's that has a large front shop or a grocery store type store with a pharmacy added on, I think the belief is that if you're going to own a pharmacy, it's a pharmacy, stop, period, end of story.

What a pharmacy is there for is to give information to the patients and to provide appropriate drug therapy to those patients. It's not there for convenience reasons, to sell Kleenex boxes, to sell vegetables, to sell the deli products to get your sandwiches, or tobacco products. I think part of the focus has to be that pharmacy is a health profession, and pharmacies should be looked at in that way.

**Mr Jim Wilson:** The reality is the act does look at it the other way too in terms of the Zellers store. They will be prohibited from selling a product.

**Ms Ventin:** Then they would have to comply with those regulations. I think if they want to take on the idea of having a pharmacy in their stores, then they should have to look at the ideas that go behind owning a pharmacy and what the principles are there for and what pharmacists do. If they have problems with that, for example, the removal of tobacco from those stores, they'll have to rethink their decision of bringing a pharmacy into their store.

**The Chair:** Last question, Mr White.

**Mr White:** We've had a lot of discussion about pharmacy. That's been one of the major issues before our

committee. We haven't talked too much about school yard smoking and other kinds of phenomena, but there have been a lot of pharmacists who've come in front of us on both sides of this issue. Many pharmacists say they're retailers; others say they're health care professionals.

I'm wondering, seeing as you're in the process of graduating and becoming licensed pharmacists in the province of Ontario, how many courses did you take in your degree, or will you be taking by the time you complete, whose focus is on retailing?

**Ms Sabharwal:** None.

**Mr White:** None. Are you aware that some 17% of the tobacco product in this province is sold in pharmacies, which would equate to the death of about 2,000 people a year? That creates a moral dilemma, I would think.

**Ms Sabharwal:** Exactly. That's what we see the debate as, a moral and professional dilemma. Obviously it is a professional dilemma, since many professionals can't seem to figure out whether it is retail, just even trying to figure out what pharmacy is. It's a professional dilemma for some professionals. This is the problem, and that's why we feel the debate should centre on the fact that it is an ethical dilemma and not an economic one.

**Mr White:** Clearly your course of study has not entailed one single course in retailing.

**Ms Sabharwal:** No.

**Ms Ventin:** I think that was a really good point, that there are so many deaths with smoking, and that's why we do take a very strong stand in that we feel that our role is in smoking cessation. That's what we really want to accomplish.

**Ms Sabharwal:** I think any health professional right now should realize that the goal is now towards health promotion, and it's impossible to do that when, at the same time, you're selling a product that you know will cause your patients harm. Pharmacists should realize that role, that they should be a resource for patients to have a healthier lifestyle, not an unhealthy lifestyle.

**The Chair:** Thank you again, all three, for coming. It's been a long day, but we really appreciate it and found your presentation most interesting.

**Ms Sabharwal:** I'd just like to thank you again and as well mention that we will have a written submission handed in tomorrow, but unfortunately we've had quite a bit of homework to do.

**The Chair:** That's good to know, because we're interested in standards too.

Members, just before you leave, again to remind everyone that we reconvene on Monday in London at 11 a.m. It's London, Ontario, Mr Eddy, in case anyone is thinking of heading to England. On Wednesday we are in Sudbury.

With that, the committee stands adjourned until 11 o'clock Monday morning in London.

The committee adjourned at 1744.











## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

\***Chair / Président:** Beer, Charles (York-Mackenzie L)

\***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

\*Martin, Tony (Sault Ste Marie ND)

\*McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Arnott, Ted (Wellington PC) for Mrs Cunningham

Duignan, Noel (Halton North/-Nord ND) for Mr Hope

Haslam, Karen (Perth ND) for Ms Carter

Perruzza, Anthony (Downsview ND) for Mr Rizzo

Wessinger, Paul (Simcoe Centre ND) for Mr Hope

White, Drummond (Durham Centre ND) for Mr Owens

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service

Gardner, Dr Bob, assistant director, Legislative Research Service

## CONTENTS

Thursday 3 February 1994

<b>Tobacco Control Act, 1993, Bill 119, <i>Mrs Grier</i> / <b>Loi de 1993 sur la réglementation de l'usage du tabac,</b></b>	
projet de loi 119, <i>M<sup>me</sup> Grier</i> .....	S-819
City of Toronto, department of public health .....	S-819
Dr Perry Kendall, medical officer of health	
Medical officers of health for the greater Toronto area .....	S-822
Dr Jim Mitchell, medical officer of health, city of York	
Dr A.M. Egbert, medical officer of health, city of Etobicoke	
Royal Canadian Legion .....	S-825
Jack Currie, veterans' service officer, Metropolitan Toronto	
Pharma Plus Drugmarts Ltd .....	S-828
Rochelle Stenzler, president and general manager	
Tim Carter, public affairs manager	
Addiction Research Foundation .....	S-835
Mark Taylor, president	
Dr Roberta Ferrence, senior scientist and director, Ontario tobacco research unit	
Medis Health and Pharmaceutical Services .....	S-840
Frank Goodman, Ontario regional vice-president	
Samuel Hirsch, past president	
Ruth Mallon, president	
Karen Graham .....	S-845
A&P Drug Mart Ltd .....	S-847
Phil Rosenberg, director and general manager	
Regional municipality of Hamilton-Wentworth .....	S-850
Dominic Agostino, chairman	
Barry Phillips .....	S-852
Ontario Naturopathic Association .....	S-855
Patricia Wales, executive director	
Richard Stein .....	S-856
Council for a Tobacco-Free York Region .....	S-858
Joanne Kaashoek, chair	
Tania Gabrielle, high-school student	
Linda Pugilese, high-school student	
Fady Samaha, high-school student	
Frank Casicaro, high-school student	
Frederic Bass .....	S-861
Carmen Paquin .....	S-864
University of Toronto, faculty of pharmacy, class of 1994 .....	S-865
Mona Sabharwal, vice-president	
Tony Antoniou, president	
Arima Ventin, secretary-treasurer	

(H201)  
XC12  
-537

Government  
Publications

S-33



S-33

ISSN 1180-3274

**Legislative Assembly  
of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

Monday 7 February 1994

**Journal  
des débats  
(Hansard)**

Lundi 7 février 1994

**Standing committee on  
social development**

Tobacco Control Act, 1993

**Comité permanent des  
affaires sociales**

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 7 February 1994

The committee met at 1051 in the London Delta Armouries Hotel, London.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

BOB RIEPERT

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. I call as our first witness Mr Bob Riepert. We appreciate that you're here before your scheduled time. We'll let you kick off the proceedings.

**Mr Bob Riepert:** I'm appearing today as a private pharmacist in my 46th year of practising pharmacy, and I'm still practising.

I am in favour of Bill 119 and particularly of the part that pertains to banning tobacco sales in pharmacies. I'd like to accomplish this by making two salient and very important points. I intend to give you a very brief history from my experience going back a few years, make the two points and then sum up at the end.

I graduated in 1948. Back in the 1950s, in my pharmacy—I was working for someone then—we sold tobacco and nobody thought too much about it, except perhaps to say that it was a nasty habit to have.

As the years went along and scientific publications came out in the press, literature, books and so on, it occurred to me that the evidence was mounting rather rapidly as to what tobacco does to one's health. On a personal note, at that time I smoked a pipe. As the evidence mounted, I came to the realization in the late 1950s or early 1960s that I was playing roulette with my life and I decided, "Here I am, a health practitioner and I'm smoking." So I abruptly stopped.

It didn't occur to me at that time that perhaps I shouldn't be selling the product. That came a lot later. Anyway, I stopped as the evidence mounted, and coming up right to today, it is now a scientific fact that one cigarette will shorten a smoker's life by eight minutes.

If you want to put that on a different basis, for the second point, approximately every 45 minutes one person in Ontario is dying as an indirect or direct result of the use of tobacco products, as the cause of their particular illness. If you want to put that on an annual basis, 30,000 people are dying each year in Ontario.

Here we are, we're taught by our college and we follow our college's direction in that we counsel people every day, as well as dispensing prescriptions, on their health and all matters pertaining to the prescription and their health that we can possibly counsel them on, as we're asked or get into conversation.

We are doing this, and my first point is that this is without a doubt an incompatibility and a direct conflict in that we are trying to get people well on the one hand, and on the other hand we're turning a blind eye and saying, "We'll sell tobacco." That's my first point.

I'd like to backtrack a little bit to say that back in 1979 I was elected to the Ontario College of Pharmacists to represent district 12, which is the Kitchener-Waterloo area, Brantford, Guelph, Simcoe, down to Port Dover.

Over this period of time, and I served on the college council for approximately 11 years, this question of whether pharmacies should sell tobacco or not came up. In 1988, I was elected president of the Ontario College of Pharmacists and again this matter came up before council. In my wisdom at that time I decided to instruct our standing committee on ethics to look at this problem from an ethical point of view. This they did and after a fair amount of study on it, they came up with a recommendation that tobacco not be sold in pharmacies.

My term of presidency came to an end and I was followed by someone you may already have heard from, Dr Nghia Truong. During his term, he appointed another committee to look into this and to find ways and means to implement that pharmacies not sell tobacco products. He appointed one of our laypeople on council, Mrs Jane Chamberlin, as chairman of that committee. That committee made an exhaustive search into this question, and as you know, came up with the recommendation that pharmacies not sell tobacco products.

The Ontario College of Pharmacists of course does not have the authority to mandate our pharmacists not to sell it. We have to follow the previous Health Disciplines Act, which ended on December 31, and now we have our new act. It ended then. The committee came up with this recommendation, but the college can go no further and we are right where we are today. It is now in the hands of the government and this committee in its deliberations as to what's going to happen with this.

Our opposition, those who still want to sell tobacco in pharmacies, argue that if it isn't sold in pharmacies and it's a legal product and so on, then those who wish to buy it will just go somewhere else and buy it.

Yes, ladies and gentlemen, that's true, they will. By the way, I belong to the Ontario Pharmacists' Association as a member and their policy, as you may have already heard too, is that this be done on a voluntary basis. I've no objection to this, and indeed as of this past Friday, I ascertained from the Ontario Pharmacists' Association: "You have a reporting mechanism where pharmacies will report that they have voluntarily removed tobacco from their shelves. Can you tell me how many there are to date?" They informed me that 900 pharmacies have voluntarily withdrawn the sale of tobacco.

You must remember this is a voluntary submission, and of course there are more than that; I can't tell you

how many more, I just know there are more. With the college, having served on council for all those years and been president, I also know that many pharmacies voluntarily, after the college made that direction, gave up the sale of tobacco. I don't know how many because no one was asked to report, and if they did, I don't even know whether anybody kept track of it. However, the OPA has kept track of it and they tell me it's 900.

1100

I present the challenge to this committee and to the government that the time has come. We've tried the voluntary, and that's fine. It would go on and we'd still get more people, but we'd just wander along and a few more would join and we'd never really have everybody.

I stated to you today that in my opinion the time has come for this government and this committee in its deliberations to accept the challenge and say, "Sure, it can be sold any other place," but I say to you that this government should set an example to the people of Ontario.

It's a small beginning maybe, looking at the overall picture—I'm sure you're aware there are 2,200 pharmacies. This goes up and down a little bit as some close and others open, but as of Friday there are 2,200 pharmacies in Ontario. There are approximately 8,000 pharmacists. If you pass this legislation, especially pertaining to the pharmacist part, just think of the impact this will have on other people when they realize that these are health professionals and they are no longer selling this product.

Those are my two points. In summing up, it's a direct conflict. I don't know how anyone can try to heal people the one hand and then sell something that's going to kill them on the other, as we know by our scientific facts. The second point is that while it may appear at this time to be a small step for the government to take in passing this legislation, I fully believe it will be a giant step as far as helping the rest of mankind in Ontario is concerned. I hope I haven't gone over.

**Mr Dalton McGuinty (Ottawa South):** Thank you very much for your presentation, Mr Riepert. One of the difficulties I certainly see in this matter is the division among pharmacists with respect to this issue. For instance, Pharma Plus, with 130 stores that have no connection to the tobacco industry other than through their sales, has indicated that it has some very serious reservations about the ban, as has a presenter on behalf of what you might call the non-traditional pharmacists. I think there are about 160 in the province, like K mart, Zellers, Loblaws.

I know people have made the point several times that they have difficulty with the symbolic element, this contradiction you explained to us of being someone who both provides a form of health care and at the same time sells a product which is obviously harmful to health. The symbolism associated with that is something we'd rather not have in place.

What about the non-traditional people, where we go into a huge store and the cigarettes may be sold 50 yards away from the pharmacist, who is not connected with that whatsoever? Do you think we should be making an exception in that case?

**Mr Riepert:** No, I don't. If I could just add, I cannot speak directly for some large store, but I can speak for some stores in the Kitchener-Waterloo area that I know have voluntarily given it up. I owned three stores at one time. Two of them sold tobacco and one did not. In selling the one company which had the two stores to one of my pharmacy employees some years ago, he eventually also came to the same conclusion that I did, particularly about the time that the college recommended that they not be sold, and he voluntarily took the tobacco out. He sold a lot. I'm not saying he sold as much as some of these larger stores. The overall picture, without going into a lot of detail, was one that was positive.

Yes, I can tell you, that on average, sales will drop, but with the pharmacists I've talked to, and I've talked to five or six in the area and other pharmacists in the province, all I've heard is that eventually pharmacists, from a business standpoint, being entrepreneurial as much as anybody else is entrepreneurial in business, have found other ways to make up this loss about which our friends who are opposing this say: "Oh, I can't do that. There'll be 10,000 jobs lost and 300 pharmacies closed." That's a figure that's come up that you may have heard.

As a matter of fact, I don't know whether you've heard more about that or not, but the firm of Coopers and Lybrand has been engaged by one of the groups in opposition to taking cigarettes out to find out whether this would really happen. I don't know whether you've heard the answer to that. I hope you'll ask.

I'm just saying that they found ways around it and the overall approach has been positive. People have gone elsewhere but are still coming to the pharmacy, and I think they've been held in rather high esteem in the long run because they did that.

**The Chair:** I regret our time is up, but on behalf of the committee, Thank you for coming this morning.

HURON COUNTY HEALTH UNIT

**Dr Maarten Bokhout:** I apologize to the committee for my slight tardiness. I was following one too many trucks, I think.

My name is Maarten Bokhout. I serve as the medical officer of health for Huron county, and it is in that capacity that I'm making a presentation to the standing committee on social development on Bill 119. I think a copy of my presentation has been circulated to members of the committee and I'll proceed to read it.

It is a privilege for me, as medical officer of health for the county of Huron, to make a presentation to the standing committee. I thank the committee for giving me the opportunity to present in London, Ontario, therefore saving me the time and expense of having to travel to a more distant location.

I wish to applaud the government of this province in introducing this legislation in the face of continued opposition from tobacco manufacturers, tobacco-owned retail pharmacies such as Shoppers Drug Mart and the passive opposition of many Canadians who prefer to stay addicted, while at the same time expecting that the consequences of their addiction be paid for out of the public purse.



It takes courage for a government to take such a stand in today's economy when it is clear that there may be adverse short-term economic consequences in terms of lost revenue to the government. I applaud this government in being willing to sacrifice short-term financial gain in favour of long-term rewards in improved personal health and reduced health care expenditures, which would be a consequence of the successful passage of this bill.

As medical officer of health, I have been responsible for a number of programs which seek to work with residents of the county to lessen their exposure to tobacco smoke. These programs include workplace education programs, the promotion of bylaws which seek to restrict smoking in public places, and designating staff to address these and other techniques which seek to reduce public exposure to tobacco. I wish to discuss three aspects of this act and how it helps us to do our work as public health professionals.

The act proposes limiting accessibility to young people through the restriction of sale of cigarettes to minors and reducing the number of places in which they can be made available.

I fully support the provisions of this aspect of this act. Limiting tobacco availability and restricting its sale more effectively to minors can only be helpful. The effective elimination of such sources of an addictive substance will save many lives over the next two or three decades.

1110

The act addresses a role for inspectors. In my view, some sort of inspection function is vital and needs to be supported. I wish to point out that we, as health units, are charged as a health unit under the Health Protection and Promotion Act, 1990, to carry out inspection of premises to ensure that foodstuffs offered for sale are safe for human consumption. It does not seem inappropriate for health unit staff to participate in the enforcement function as envisaged in Bill 119. Such enforcement can be achieved at minimal additional cost and indeed could be self-financing through the sale of appropriate licences.

Finally, I wish to comment on the portion of the act which deals with packaging and packaging requirements. I am in full support of the elimination of flashy packaging for a substance which kills when taken as prescribed. I fully agree it will not be possible to eliminate the use of tobacco in this society—this is explicitly acknowledged in the act—but it is important to make it a less glamorous substance to consume. Plain packaging will assist people prone to the clever manipulations of advertising agencies and their paymasters, the tobacco companies, which market this killing substance so aggressively.

Although not specifically addressed in the act, the taxation of tobacco has in recent years been a cornerstone of government policy to reduce tobacco consumption. At present, these taxation policies are threatened through the concerted efforts of tobacco manufacturer lobbyists, lawbreaking smokers in Canada, especially in the province of Quebec, so I understand, and the continually increasing government requirements for more money. There is currently momentum to reduce cigarette taxation so that smuggling will not be as attractive an option and so that more people will buy their cigarettes legally, thus

contributing to government revenue.

Reduced cigarette taxation will in part subvert the intent of the Tobacco Control Act. I, along with many other associations, including the Association of Local Official Health Agencies, support the position that a more sensible way to go is to re-introduce an export tax on cigarettes. This will address in part the need for increased government revenue, while at the same time partially eliminate the financial incentives which make the purchase of smuggled cigarettes such an attractive option at the present time.

At the same time, a better understanding of the social costs of smuggling, that is, corruption of public officials, organized crime, greater costs for law enforcement etc, needs to be disseminated to the public so that they realize what the outcome of their willingness to flout the law may be.

I enclose some documentation from the committee from the Ontario Campaign for Action on Tobacco on the subject of professionalism in pharmacy, as well as some additional background information.

Once again, I sincerely express my appreciation for being allowed to make this presentation and my admiration for the courage of this government to introduce such legislation at this time.

**Mr Jim Wilson (Simcoe West):** Thank you, Doctor, for your paper. I think that I and my party would agree with about 98% of it. As you know, our position on this act has been supporting it on first and second readings in the Legislature. We do seem to be a bit bogged down over the retail pharmacy question. We see it as a freedom of business issue. Along that line, while you're applauding the government, you mention that there will be short-term revenue losses to the government, and given that we haven't seen any evidence to date that the actual consumption of cigarettes will go down with the ban of sales through pharmacies, I'm wondering how you make that statement. The only evidence we've seen of lost revenue to the government so far is the Coopers and Lybrand study which shows 2,700 job losses.

**Dr Bokhout:** I would suggest that based, first of all, on anecdotal information that I have, not every pharmacy in Huron county sells cigarettes and those that don't seem to do quite well. I believe that in some cases it's done purely as a business decision. I spoke to one pharmacist on Saturday who made a conscious effort as an independent pharmacist to get rid of the cigarettes in his store, and he didn't suffer personally.

I think the freedom that you suggest to do business is there, but I think pharmacies also send a certain social message. I have a concern, as a physician, that you have a professional group of people, who are there to assist all of us in safeguarding the health of people, engaging in an activity which may or may not gain them some financial compensation, but clearly can contribute to the ill health of the people they serve. That to me seems to be an inconsistency, and that's the concern that I carry.

The studies: Yes, I appreciate what you're saying. Some of it may be conjecture, but what I try to do in my work as medical officer is that I try to synthesize a whole

bunch of related studies, and it seems that on balance, even though there may not be any direct evidence at this time for a particularly narrow question, the broad thrust is supportive of the concept that you balance one off against the other, and that the net effect will be less of a revenue need for government.

**Mrs Karen Haslam (Perth):** I'd like to look at the enforcement. You mentioned that the health unit does inspection, and I think that in any piece of legislation, especially like this one, enforcement is going to be the key. Does the health unit think that it can, within its budgetary resources now, effectively do some of the enforcement for this piece of legislation?

**Dr Bokhout:** What we've had to do to accommodate the increasingly tight financial circumstances under which we operate, is that we've had to reset our priorities in some cases, and that's been a fact of life for a number of health units. I've had some discussion with my staff over the last several months about the possibilities. The kind of inspection that would be required to ensure compliance with the act, as proposed, in my view wouldn't entail a great deal of extra time. It may well be that we'd have to juggle some of our priorities if no additional funding was made available, but I don't think it would be an onerous burden.

If the government chooses to use a licensing type of system, some of that money could be plowed back into enforcement agencies, which conceivably could be health units and therefore make some additional money available for the enforcement.

**The Chair:** Thank you for coming from Huron to London to make your presentation. We appreciate it.

COUNCIL FOR A TOBACCO-FREE ONTARIO,  
SOUTHWEST REGION

**Ms Isabel Hill:** My name's Isabel Hill and I am a representative of the Council for a Tobacco-Free Ontario from the southwest region. With me this morning is Tiffany Major, a student at an elementary school in St Thomas.

Mr Beer and members of the standing committee on social development, I'm glad to have this opportunity to speak on behalf of a fairly large group of people. Our groups represent 10 counties in the southwest region of Ontario, where the tobacco belt is located.

At this time, I'd like to ask those who are here today to stand to be recognized. Would my colleagues from the southwest region stand, please? The people standing represent some of the counties in southwestern Ontario who are in attendance this morning, and I appreciate their support at this time.

As with our provincial body, the Council for a Tobacco-Free Ontario, the members of these 10 councils include representatives not only from health agencies, but from many sectors of our community and people from all walks of life. We, as members, represent youth, seniors, adults and people who work in pharmacies, health care institutions, schools, restaurants, offices and factories. We have non-smokers, ex-smokers and even some smokers. I'm told, in some councils. In short, we represent our communities and for that reason I believe speak well as

a general population of Ontario indeed in supporting the bill.

At this time, I'd like to applaud the government for introducing Bill 119 at second reading and we're anticipating a successful third reading in the not-too-distant future. We are especially relieved to see the parts that will make it more difficult for young people to get cigarettes.

Our local studies are in agreement with the provincial polls showing strong public support for these measures. Even though most of Ontario's tobacco is grown in our region, we still don't want our children to become smokers. Smoking rates in some parts of southwestern Ontario are significantly higher than the provincial average. Our guest this morning, Tiffany, is with us to give evidence of the smoking problems we face.

1120

**Miss Tiffany Major:** It's easy to get cigarettes. My friends and I buy them at the corner store. It's hard to quit.

**Ms Hill:** Since nicotine is as addictive as heroin or cocaine, quitting is a major difficulty. That's why it makes good sense to those of us working in the councils to take measures which would make it more difficult for children to get cigarettes. The fines for retailers as specified in Bill 119 are substantial but they will not be effective if there is not adequate provision for enforcement.

This is a serious matter affecting the health of our children and this needs to be reflected in the legislation, particularly by laying out enforcement procedures. I suggest public health inspectors, inspectors from the various government bodies, and perhaps police officers or some other personnel could become involved in this enforcement. When combined with education, the enforcement will not be a costly measure. In the United States, where legislation has been passed with strong enforcement measures, smoking rates among young people have dropped greatly.

I believe generally that people in Ontario believe, as we do, that cigarettes should be sold only by licensed retailers and that proof of age ID should be required. Along with enforcement, these strict measures are the only sure way of eliminating the sale of cigarettes to minors. The age of majority card that's currently used to buy alcohol would be a convenient way to do this age check.

We've tried educating our retailers as to the age that children should be allowed to buy tobacco and it's not sufficient. We need to do more. Despite the existing laws that prohibit tobacco sales to minors, it is estimated that there are over \$400 million in sales to this age group per year in Canada. Retail supplies the biggest portion of that, 80% at least.

A necessary adjunct to these measures is a ban on tobacco vending machines. This measure is also supported by people in Ontario. No other product that is illegal for minors to purchase is sold through unsupervised vending machines, and attempts at controlling these sales have been very dismal and certainly anything but



successful. Finally, although tobacco advertising has been banned, we know that it's oh, so subtle, that indeed it continues in many ways. However, the proposed legislation can help to eliminate one blatant form of tobacco advertising: tobacco packaging. I urge the government to think of this seriously. Tobacco advertising takes place every time somebody takes a package of cigarettes from their pocket or their purse, an average of 25 times a day or more.

Research shows that packages with nothing on them but a warning of the risks will have almost no appeal to young people. If the government is to continue to allow such a lethal product to be sold, it shouldn't be sold in the sophisticated, alluring packages that the tobacco companies have designed to lead us to believe the product is safe and even good for us.

It's in your hands. I urge you to put forward legislation which will protect our children and our society from this costly health problem.

**Ms Haslam:** Tiffany, don't be scared. I used to teach school and we're not here to embarrass you. We just really want to get a handle on the problem. You say that it's very easy to buy cigarettes and it's hard to quit. Do you smoke now or have you smoked?

**Miss Major:** I used to.

**Ms Haslam:** You used to smoke. What age level did you start at?

**Miss Major:** Ten.

**Ms Haslam:** You say it's very easy to get them from corner stores. What kind of education is in your school about smoking?

**Miss Major:** I don't know.

**Ms Haslam:** You haven't seen any lately? Okay. I understand that Ms O'Neill may want to ask a question, so I'll be very quick.

I'll ask you one more question. Tiffany, if we were to do one thing to educate people of your age not to smoke, what would be the one message that educators could give you or that we could put in place that would say, "Do not start smoking"?

**Miss Major:** That it's not good for your health.

**Ms Haslam:** Not good for your health: That message will be understood? That message is out there and it doesn't seem to be working. You feel that if we continue doing that type of advertising, it would be beneficial to people your age.

**Miss Major:** Yes.

**Mr Ron Eddy (Brant-Haldimand):** Thank you for your presentation. It's certainly useful information for the committee. The question I ask of many presenters is information about the underground economy and contraband cigarettes, because it appears that regulations regarding the sale of legal cigarettes are being obviated by the fact that there's so much contraband.

What about the prevalence of contraband? Is it very evident in southwestern Ontario and at school yards and that sort of thing? Would you care to comment on that, please?

**Ms Hill:** I don't believe that's exactly the issue we're

here to address, but yes, I'm sure that it is available to children in all school yards, that many of them undoubtedly do purchase tobacco products through that system.

**Mr Jim Wilson:** Thank you very much for your presentation. We've had a lot of presenters appear before the committee and really tell us that the current model isn't working very well. All this act does is raise the age by one year, to 19, and make stiffer penalties for retailers or anyone who may furnish cigarettes to someone under the age of 19. It's essentially the same model we've used for ever and a day.

What we've been doing is trying to float the idea of making it illegal to consume cigarettes or to be in the possession of cigarettes under the age of 19. We do that with alcohol. Ms Cunningham was successful in getting a bicycle helmet bill through. We make it illegal not to wear a bicycle helmet, for example, for young people.

I am just wondering, rather than continuing to punish those who sell them—there still obviously has to be tough enforcement, but why shouldn't we also put some responsibility on young people that they not smoke under the age of 19?

**Ms Hill:** I think you're going at it the wrong way in assuming that it's the victim who has to change. It's we who have to change, as the public, as the government to make sure that people like Tiffany are no longer subjected to this. She isn't perhaps at an age where she ever could have chosen wisely for herself. Perhaps her parents are smokers and so she had modelling behaviour at home that suggested smoking was a healthy type of lifestyle. We need to protect her until she can reach a good conclusion for herself and decide to remain a non-smoker, or to stop smoking as she has done.

1130

**Mr Jim Wilson:** But we make alcohol illegal, make consumption under the age of 19 illegal. Parents drink, give examples to children and we still make it illegal. We've had all kinds of witnesses saying tobacco's worse than alcohol, and certainly its addiction is worse than alcohol.

**Ms Hill:** I think there is some merit in what you're saying, that it should be illegal, but I still think you're punishing the victim, going at that from the victim's point of view, and we need to change and not make it so that the victim is punished. They're already punished sufficiently now. The tobacco company needs to change that advertising. We need to have that in force, that the packaging has to be less attractive to these children to choose.

**Mr Jim Wilson:** I agree with you on that point.

**The Chair:** Thank you, Ms Hill and Tiffany, for coming before us this morning. We appreciate it.

MIDDLESEX-LONDON HEALTH UNIT

**Dr Verna Mai:** We represent the Middlesex-London Health Unit. I'm Dr Verna Mai, an associate medical officer of health of the health unit, and this is Mary Ann Morgan and she's director of information resources at the health unit. This is my second opportunity to have a say about this Bill 119 before you, and I'm pleased to have that opportunity.



The Middlesex-London Health Unit is one of 42 public health units in Ontario providing programs and services to the community to promote and protect health.

In 1989, the new mandatory program guidelines for health units were published by the Minister of Health. These are the guidelines. This was under the terms of the Health Protection and Promotion Act. These guidelines include, for the first time, tobacco use prevention as a distinct program to be delivered to our communities as a basic public health program.

I just want to review the goal of the tobacco use prevention program that's in our basic guidelines here. The goal is to improve the health of the population by eliminating tobacco use. That's a provincial public health program goal.

There are three specific objectives in these programs.

The first is to increase the percentage of the adult population that does not use tobacco to 85% by the year 2000. Looking at data from the Ontario Health Survey for our area, which is Middlesex-London, it was estimated in 1990 that 61% were non-smokers. Southwestern Ontario has reason to be even more concerned about tobacco, since men aged 15 and over smoke significantly more in southwestern Ontario than in the whole of Ontario. In 1990, 31% of southwestern Ontario males were daily smokers, compared to 25% in all of Ontario. So you can see that if we want to reach our goal of 85% by the year 2000, we have quite a ways to go.

The second objective is to increase the percentage of the population aged 12 to 18 that does not use tobacco to 90% by the year 2000. In 1990, 83% of the teen population were non-smokers in Middlesex-London, again indicating we have a way to go.

The third objective of our program is to increase the percentage of the population not exposed to secondhand smoke daily to 70% by the year 2000. The Ontario Health Survey estimates that 37% of those surveyed aged 12 or more were exposed to secondhand smoke in their household. The thing to note here is that the exposure in the workplace and other settings was not considered in this survey. Again, to reach 70% it's clear there is still much work to be done.

We commend you for bringing forth Bill 119, which will move us towards a smoke-free society.

The World Health Organization states, "Health promotion combines diverse, but complementary, methods and approaches including communication, education, legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards."

With this legislation before us, we have a perfect example of a government showing leadership in bringing forth healthy public policy to complement other health promotion strategies that are in place already, such as health education in the schools, taxation of cigarettes and social marketing campaigns to counter the tobacco industry's false images of glamour and smoking. "Smoking is not a pretty picture" is one campaign that the Middlesex-London Health Unit is involved in.

Policies that are healthy help to set the stage for health

promotion because they make it easier for people to make healthy choices. In this case, we are facing a major challenge, with a lethal, addictive product that causes 13,000 deaths in this province each year. Yet it is one that has been historically accepted and commonly used.

Once a substance is discovered to be linked causally to illness, it has been eliminated or removed in the past. A good example of this is asbestos, which also causes lung cancer.

What is the difference with tobacco? The difference is the powerful influence of a profitable tobacco industry, concerned only with the bottom line in business profits, and we applaud you for the introduction of such tough legislation.

We support the following, which are all covered in Bill 119: the raising of the legal purchase age to 19; banning of sales in pharmacies and other health facilities; banning sales from vending machines; posting of health warnings and age limits by retailers; the banning of smoking in health facilities and designated public places; health warnings and information included with packaging; and enforcing the legislation with fines and bans on the sale of tobacco.

These measures will educate the community, limit access of youth to a lethal and addictive product, which most certainly would not be legalized today if it was developed, and it will also show those who are in tobacco retailing that selling to underage teenagers is not acceptable.

In addition, we recommend that the government move even further towards the goal of preventing the provision of tobacco to young persons and regulating its sale and use by others by considering the following:

The licensing of all tobacco retailers. This would treat all retailers the same and get the message across that selling tobacco is a serious business with health consequences if guess, regulations aren't abided by.

We suggest the banning of kiddie packs and requiring plain packaging through regulation on packaging. I know there's a provision for packaging, and we'd just strongly support that this be covered in that regulation.

Finally, we think that because of the harm of environmental tobacco smoke, prohibiting smoking in all workplaces and all public places would be another consideration.

Remember, governments have a vital role to play in protecting and promoting the health of the public, and we have to remember that health is not just an end in itself, but it's a resource for everyday living. That is why it is so important for this government to act on this groundbreaking yet very logical legislation to optimize our community's health.

Now I'd like to present Mary Ann Morgan.

**Ms Mary Ann Morgan:** I join Dr Mai in congratulating you on Bill 119 and thank you for the opportunity to speak with you here in London. I know you've heard many reports, statistics and strong opinions during these hearings. Today I want to present a human interest perspective on this whole issue. This information comes from a modest study, from information from adolescent

focus groups and from personal observations. In 1991, we in health promotion at Middlesex-London Health Unit wondered if minors in London could actually purchase cigarettes in our community as we had read about in other communities. We asked friends who had adolescents aged 13 to 15, so that they could not possibly be mistaken for anybody who was 18, to take part in a minor's purchase attempt. We developed the plan and selected retail outlets across the city: 20% of our retail outlets were willing to sell cigarettes to a 13-year-old female adolescent; 44%, and we're talking about 1991, were willing to sell to the adolescent male; and 89% were willing to sell to the adolescent female who was 15 years old.

There were some poignant and disturbing moments as we conducted the study. One retailer in a downtown environment which attracted many teens where we had anticipated tobacco might be sold was very strict with this young man who went in, who was 13 years old. They said in no uncertain way: "You're too young to smoke. We do not sell tobacco to young people. Go home and talk to your parents about this." That was a really wonderful experience for us.

But then in other places clerks recommended that our young people go down the street to purchase cigarettes where it was less expensive; they just recommended that. The other one is that we saw that some clerks actually prompted the adolescents who participated in this study; for instance: "How old are you? Are you really 15, 13?". Then they would wait until the store was empty and would prompt them again.

In 1993, last year, we conducted focus groups with young women about tobacco, and one smoker, not unlike Tiffany whom you just met, said: "It's a bad habit. I have to quit because it affects my breathing for sports. Some people steal from their parents." Many told us that young people smoked in order to be cool and to be part of the group, and others told us that the hair, breath and clothes of smokers smelt bad and they wanted to be attractive to their boyfriends.

1140

Last week, at lunchtime, I entered a pharmacy and as I was waiting in the checkout line I was delighted to see a sign right on top of the cashier which states that cigarettes would only be sold to people who were 18 years or over. There were two young women in front of me, obviously high school, talking high school, because my children have recently left high school. Each ordered a package of cigarettes. Each purchased a package of cigarettes, no questions asked, and I wondered about the meaning of the signage there.

There has been much discussion about the sale of tobacco in pharmacies and we should be wary about singling out the sale of tobacco only in pharmacies. We applaud the government on banning the sale of tobacco in pharmacies, but selling tobacco in any retail outlet is a problem we must address, and the logical solution is to sell in licensed outlets.

I'm sure you know that for every 100,000 smokers now aged 15, the following deaths will occur before the age of 70: 1,200 from car accidents, 900 from suicides,

130 from homicides, 10 from drug abuse, a few from AIDS and 18,000 preventable deaths caused by tobacco.

Remember how you felt when the Air India disaster and the Pan American disaster over Lockerbie occurred several years ago. Remember your indignation and ire. Put yourselves for a moment into the sorrow, grief, pain and anger of those surviving relatives as they dealt with the preventable deaths of their loved ones. On the human interest side, we should know that 18,000 deaths means 108,000 survivors, since there are roughly six survivors per death. That's 72 preventable jumbo jet airline disasters that we are talking about.

The other thing we should remember is that bereaved survivors have more hospitalizations, more physicians' visits, use more drugs, have more sick time and loss of productivity than their non-bereaved counterparts. We are here dealing not only with the premature deaths of 18,000 people, but we're also dealing with the health care costs associated with 108,000 survivors.

It's easy to talk about numbers and statistics, but there are always faces behind these numbers and statistics. We are talking about your children and my children, your nieces, your nephews, your grandchildren and the children of our friends and relatives. Tobacco deaths are preventable. Bill 119 is a good effort and we ask you to strengthen the legislation: banning kiddie packs, selling tobacco only in licensed outlets and prohibiting smoking in workplaces and all public places.

We appreciate the opportunity to present to you today and applaud the government on its legislation.

**Mrs Dianne Cunningham (London North):** Thank you both. I've been aware of some of the studies going on in London, having been involved with the Lung Association and others when I wear my other hat, so I'm glad to see the health unit here in the forefront.

I'd like to ask a question, because you're saying that you're happy the legislation is strengthened. Some 10 years ago, when we were working on these kinds of things like a smoke-free workplace, if you remember, the school board programs and all the kinds of things we tried to do together, we were cautioned not to move too quickly too soon by both of the professional groups in this city.

In this instance, I think one of the things we're facing is that there has to be responsibility on behalf of young people too. You said you wanted to see stiffer legislation. What about making younger people responsible?

You mentioned also, Mary Ann, that you're a mother of young people who have finished high school, and so am I. I can remember saying to my kids, "If you go in to some establishment and drink under age, the person could lose the licence to run the restaurant," putting the onus on them. What about young people going into stores to buy these cigarettes, like the two young people in the pharmacy? I'm wondering if, not on behalf of your group but as an individual, we shouldn't be looking at some kind of a fine or a penalty for people who actually break the law.

**Ms Morgan:** I believe there is already a fine for youngsters who are caught purchasing. It's a very small one, I believe.



**Mrs Cunningham:** I don't think so.

**Mr Jim Wilson:** There's a 1905 act of Parliament.

**Mrs Cunningham:** It's never enforced.

**Ms Morgan:** No, it's not enforced.

**Mrs Cunningham:** It's nothing teachers tell me in schools, because I was speaking on this subject twice last week in the schools in London, that they can tell the young people. The health teachers are telling me they can't go in a classroom and say to the students: "You will get a fine. You're responsible."

**Ms Morgan:** I think you raise a really interesting question.

**Mrs Cunningham:** I'm just wondering; I'm not being controversial.

**Ms Morgan:** It becomes a chicken-and-egg thing. Partially in health promotion we tend to get caught up in, where do we start? I think we have to start everywhere. This legislation is one of the strongest that we have seen and it is a good start. It does mean that we won't continue to educate and perhaps even look at other supporting issues. But I do support Isabel Hill in what she said in terms of blaming the victim, that we have to be very careful of that. We are talking about change and we are talking about change over time. Wherever you start, we will see, I'm convinced, change over time, if we're willing to wait the number of years it will take.

**Mr David Winninger (London South):** Thank you for your informative presentation. It's a little troubling to me to hear that the incidence of tobacco consumption tends to be higher in southwestern Ontario than the average across the province. I suppose you've provided one reason, and that appears to be the unethical marketing of tobacco products to young people. Can you think of any other reasons why it would be more prevalent in this area than elsewhere?

**Dr Mai:** It's probably because this is where tobacco is grown, largely, in southwestern Ontario, so the attitudes towards tobacco are probably a little bit different than elsewhere where it's not grown.

**Mr Winninger:** I see. Obviously, the Middlesex-London Health Unit has been taking some initiatives before now to deal with it in the schools. Are there any other kinds of measures?

**Ms Morgan:** As I said, we started to do some research to conduct some background information to do that when I came to the health unit, which was at the end of the 1980s, and we have been doing that. Our public health nurses have also been very actively involved in teaching parents and bringing up tobacco issues in prenatal classes. Yes, health units have been involved for a long time. I think we are becoming more involved as we see this as a serious problem.

**Dr Mai:** You must remember that until 1989, when the mandatory programs actually identified tobacco use prevention as a distinct program, it was something we did but it was not pulled together as a specific objective for public health.

**The Chair:** I regret our time is limited, but we want to thank you both for coming before the committee today.

#### COUNCIL FOR A TOBACCO-FREE LAMBTON

**Ms Cathy Bourke:** I'm Cathy Bourke from the Council for a Tobacco-Free Lambton. Accompanying me is Carolyn Andrews, also from the council. Our council represents the Lung Association of Lambton County, the Lambton health unit, Chippewas of Sarnia substance abuse program, the Lambton County Board of Education, the Lambton County Roman Catholic Separate School Board, an occupational health nurse from the community, the family counselling centre and the Addiction Research Foundation of Lambton.

We'd like to thank the standing committee on social development for the opportunity to speak to you this morning. We appreciate the Minister of Health's commitment to this progressive health legislation, Bill 119.

Tobacco and Your Health, the report from the chief medical officer of health, 1991, states: "Tobacco-related diseases are the province's number one public health problem. The cost of human lives, quality of life and health care dollars is colossal. The circumstances call for nothing less than thorough and relentless action by all Ontarians."

As a local council with common concerns, we work on projects to prevent tobacco use in Lambton county. One of our main focuses is youth. We know that smokers rarely begin their habit after 20. Therefore, if we are to curb addiction, we must pay special attention to children and adolescents. If we can stop tobacco use at early ages, we can greatly reduce the number of adult users. For these reasons, we highly endorse the government's efforts in Bill 119 to reduce access to tobacco for youths.

#### 1150

The Council for a Tobacco-Free Lambton conducted a brief survey in one local high school last week, on January 26, to see how easily students could purchase tobacco underage. Some 447 surveys were distributed to grade 9 and 10 classes at the Sarnia Collegiate Institute and Technical School, a high school in Sarnia, and 410, or 91.7%, were returned, with the following results. Of the 410 that were returned:

—216 students indicated that they had indeed purchased cigarettes underage.

—194 indicated that they had not purchased cigarettes. However, of these 194, only four students indicated that they had approached a retailer and been refused. In other words, of the grade 9 and 10 student body in that particular high school, 54% had purchased cigarettes underage from retail establishments, and of the remaining 46% that did not purchase, only 1% had tried to purchase and been refused.

—201 student replies indicated they had purchased cigarettes in a convenience store, gas bar or grocery store.

—82 students indicated they had been successful in purchasing cigarettes from pharmacies or drugstores.

—74 students indicated they had purchased cigarettes from vending machines.

—Of the 216 students who indicated that they buy tobacco underage, 140, or 65%, claim that they have never been asked for identification. Eighty-two of this same group state that they have never been refused a sale,



while the remaining 134 have been refused only on occasion.

The survey indicates that over one half of the youths in grade 9 and 10 in this high school can purchase cigarettes underage. This would also suggest to us that the government's efforts in reducing accessibility to tobacco for youth in Bill 119 is well worthwhile. We are particularly pleased with the provisions of Bill 119 which directly affect youths' ability to gain access to tobacco products, but would like them strengthened in some areas.

We would like to present to you the strengths and concerns we have identified, as follows:

—Raising the age limit to 19 and having to produce a prescribed form of identification: The act should be amended to specify acceptable pieces of identification that have both birthdate and picture; for example, the age of majority card, passport, driver's licence.

—Signage clearly posted at the retailer that indicates age to purchase: This allows for no misinterpretation of the age requirement by both the retailer and the purchaser.

—Banning vending machines: We strongly support this, as local youth in our survey indicated this to be an easily accessible route to purchase.

—Prohibiting smoking in designated places, including schools: This is already a policy established in all Lambton county boards of education, but we would like to see a consistent policy across the province to protect youth.

—Strengthening non-compliance penalties: In particular, we support the government's position that on second or subsequent offences the retailer would be prohibited from selling tobacco products for six months. However, by licensing retail tobacco distributors, it would more effectively address enforcement issues, since few retailers would risk losing their licence.

—Enforcement: We believe it is essential to ensure that the legislation is effectively enforced and consistently applied. At present it reads, "The Minister of Health may appoint inspectors for the purpose of this act." A guarantee is needed that the government will definitely appoint inspectors. Without provisions for enforcement of this act, the legislation will not be effective.

In conclusion, we believe that this piece of legislation, with some amendments, will prevent our youth from becoming smokers. It is only by working together on this legislation that we can protect our future citizens, enhance our quality of life and reduce health care costs. Thank you for giving us this time today.

**The Chair:** Thank you very much. I just note for the record that you have also attached to your brief the survey results of the questionnaire, the investigation you did. We'll begin questioning with Mr McGuinty.

**Mr McGuinty:** I really appreciated the survey. With respect to "78 have purchased from vending machines" that I find on page 1 of your survey, do you know how many of those vending machines were located in bars?

**Ms Bourke:** That I can't tell you. We didn't ask for that information on the survey.

**Mr McGuinty:** Any anecdotal evidence on that?

**Ms Bourke:** No anecdotal re vending machines.

**Mr McGuinty:** My Conservative colleagues have raised this idea which I think merits some discussion; that is, this issue of giving youth some responsibility. I just have a great deal of difficulty thinking of an 18-year-old or a 17-year-old, or even a 16-year-old, saying: "I'm sorry, but I'm only a victim in this matter. If that man hadn't sold it to me or if I hadn't been bombarded with advertising, I wouldn't be here smoking."

Of course, we have laws in place today such that notwithstanding the very effective advertising for beer, for instance, which associates it with good times and all this kind of stuff, it's still no defence for a young person to say: "Your Honour, I was a victim. Damn it, that advertising was so effective I just couldn't help myself."

I think it's paternalistic and in reality insulting to kids to tell them that they're just victims. I think they are partners and should be seen as partners in helping to combat smoking in kids. I'd like your opinion on that. Why can't we use kids as partners in an effort to stop smoking?

**Ms Bourke:** Number one, I don't want to look at victim-blaming. I think you have to appreciate by the studies that are out there that the average smoker starts at age 12 to 13 years of age, not age 16 or 17. Usually by 16 or 17 the addiction process is there, for one thing. This legislation, which I was hoping we were addressing today, is looking at our responsibility and legislative responsibility in protecting our youth. I think it should be a cooperative effort. However, I feel we have a responsibility here as informed adults.

**Mr McGuinty:** One of the frustrations, and I'm sure you've sensed this too, is that all we're really doing here with this legislation is just nibbling around the edges. It would be nice if we could do away with tobacco completely and I'm sure you would agree with that.

**Ms Bourke:** I'd love to legislate that.

**Mr McGuinty:** Is there anything wrong in telling kids that it's wrong to smoke?

**Ms Bourke:** No, and I think we've been doing that. Right now we're looking at the legislative aspect of it: What can we do, and what can you do as a legislative body to protect our youth? Education is all-faceted. You have to look at all aspects of it. I was hoping to address this.

**Mrs Cunningham:** Congratulations on doing the survey. You know what I found interesting? That 35% of the retailers do ask for identification. That must be courageous in today's world, to say, "Show me your identification," when there's so little clout in the existing law. I just wanted to say that's good news. But thanks for the other part of the survey.

With regard to 12- and 13- and 14-year-olds smoking, it's also pretty well the age, by the way, that they start to use alcohol, isn't it? Am I correct in that regard?

**Ms Bourke:** I can't address that one directly as to age. Yes, I think you could compare it but I don't have the statistical—

**Mrs Cunningham:** I think it is. We're looking at probably sixth, seventh and eighth graders for most of these problems. Again my question goes back: I appreciate your point about enforcement. I'm thinking that you probably mean we should change the word "may"—I'm now looking at the point on the bottom of the first page—to "shall" with regard to the inspectors, which would give the legislation more clout.

1200

We also had someone earlier tell us that maybe the existing staff that's already out there within the departments of the local medical officers of health could be doing this inspecting, because one of the things I think we have to be concerned about is using what we now have in place to help us. I wondered if in your work you would have any suggestions for the government in that regard. In other words, we shouldn't be spending a whole lot of money on enforcing something. How can we work within the present system? Has your group looked at that?

**Ms Bourke:** We personally don't. We're the council that represents several bodies across Lambton county. As to the budgetary aspects within the Lambton health unit, whether they have budget in there for enforcement officers at this point in time, I can't speak to that.

**Mrs Cunningham:** What I'd ask you to do, then, is to take the question back, because there are many people who are working within different agencies and ministries of the government who could take this job on, I think. Right now the enforcement officers within the Liquor Control Act are out in different restaurants. Maybe they're the group we could be looking at. All we're looking for from the general public that are working on a day-to-day basis, and the experience within health units and what not, is how we can become more efficient in enforcement as well, because this could be the thing that comes out of it. We all know enforcement is the issue. How do we do it within the existing services? I believe that's possible.

I think the people we hire to look at restaurants right now, for instance, that are breaking laws with regard to serving alcohol could be the same people we could be looking to with regard to people who are selling cigarettes. I don't know if you could do that for us, but it would be very helpful, since you've already done all this work, to see if that could be helpful.

**Mrs Haslam:** I want to commend you. I've read your questionnaire, and it was certainly straightforward. I think what is telling is when you take a look at the results and you see that 83 have been able to purchase in pharmacies, which works out to 26%, because we've had pharmacies come before us and say: "We don't sell to students. We're the ones who don't sell to students." I find that extremely interesting that you have proved that 26% of our students do buy in pharmacies and are able to buy in pharmacies.

The other thing I find very frightening is that 136 have bought cigarettes individually, that they can actually go into a store and pay \$1 a cigarette, I assume, or whatever it is.

**Ms Bourke:** We did get some anecdotal notes on that, saying that 35 cents seemed to be the going price at one local convenience store, and anywhere up to \$1 per cigarette. That was being sold at convenience stores.

**Mrs Haslam:** That, to me, is very frightening information. I want to look at your "strengthening non-compliance penalties." You talk about licensing retail tobacco distributors. I'd like you to touch briefly on the difference between licensing retail tobacco distributors versus the ticketing process that is presently proposed in the legislation, whereby they would lose their right to sell tobacco for six months, what you see as the difference between those two and which you would rather see in place in legislation.

**Ms Bourke:** I didn't think it proposed definitely to license; it said on second offence, if I'm not mistaken, they could lose their licence; on third or subsequent, I would like to see it strengthened there possibly that you'd lose a licence entirely to sell in future.

**Mrs Haslam:** For what length of time?

**Ms Bourke:** I can't address that personally on behalf of the group, but I would like to see it strengthened that enforcement and licensing would be a definite built-in issue.

**The Chair:** Again, I regret the time, but we'll have to stop. Thank you for coming before the committee today.

#### WINDSOR-ESSEX COUNCIL ON SMOKING AND HEALTH

**Ms Elizabeth Haugh:** My name is Liz Haugh, and I happen to be chair of the Windsor-Essex Council on Smoking and Health. I would like to thank you for this opportunity to present before you today. I think you'll find that my presentation will take a little bit of a different view in that it will predominantly relate to the environmental tobacco smoke issue, and the medical officer of health who will speak after me will address the sales to minors issue.

As you can see, I'm privileged to represent several organizations in Windsor and Essex county that have an interest in tobacco use prevention. As a coalition, we have worked diligently to see this legislation get this far. When the first draft discussion paper was presented a year ago in January, we introduced it to other local agencies and social service agencies around the Windsor-Essex area. We asked them to bring it to their governing boards to have a look at it to see if they could endorse it and perhaps suggest some augmentations to it.

Overwhelmingly, the response from our community was very favourable. They really endorsed this legislation. They sent this message back to us, as well as their concerns that perhaps it could be augmented in regard to protection of the public from environmental tobacco smoke and address the issues a little more effectively on the work sites.

In March of last year we presented in Toronto our accolades for the draft paper as it was presented. We thought it was excellent. However, we did want some augmentation in some areas, and we made that suggestion.

When the draft finally became Bill 119 in the fall



session of Parliament, I have to say honestly that we were rather disappointed about its lack of ability to address the issue of environmental tobacco smoke. We thought that it did adequately address the sales-to-minors issue, and as the name of the act reflects, that's what it was to do.

However, I'm not going to sit here and bore you with the dangers of ETS. I think this is well established and well accepted within the community, just to add, though, that approximately 25% of our population has a medical condition that is adversely affected by involuntary smoking in the environment. So it is an important issue to address and I think you have an opportunity to do this.

If the province does not take action on this hazard, then of course you have to leave it up to the local municipalities. You're aware, I'm sure, of the few municipalities that have had some degree of success in dealing with this issue. Toronto, Ottawa and, currently waiting for enabling legislation, Scarborough, come to mind immediately. However, examples that have not had successes, we don't hear about, and Windsor is one of those examples right now.

As a council, we've been working very hard to try to get some local municipal bylaws passed that we feel are more protective of the public, and we're having a very difficult time. I understood that this legislation is to set a minimum level of restrictions for tobacco use in the province, and that municipalities could add their own bylaws to it for further restrictions. This is not as easy as it sounds. Local municipalities cannot just do this, because there are some political intricacies at the municipal level which act as a really strong barrier against doing this.

In Essex county, for example, we have 23 municipalities. I think you have them attached in your appendices. You'll see that only two of these have any kind of formal bylaw. To deal with the 23 municipalities individually presents an incredibly expensive, time-consuming and trying process. Just as an example, we have used, in the health unit where I also work, approximately 1,500 hours of FTE time in trying to work through this municipal bylaw exercise since November.

Local politicians who have potential campaign supporters from the business sector are very reticent to address something that could possibly alienate these groups. The local restaurant association and the business improvement association represent a large municipal tax base to local cities, towns and townships. Employers who have always allowed smoking in their workplaces are very resentful of having new rules imposed on them by local politicians, who they very often know personally.

Restaurants, for example, often resist because they hold the mistaken belief that restricting smoking is bad for business. Research has indicated that smoking restrictions have no effect on revenue and may in fact improve some businesses. However, many business people refuse to accept this, and they become resistant to the idea of any form of controls in their organizations, fearing that their counterparts in other municipalities will have an advantage if they are not operating at the same level of restrictions.

I want to share with you our experience as a council in

trying to enact our municipal bylaw. We held an extensive five-month consultation with the community, and during this time we offered a tobacco hotline that was promoted through pay TV, print and radio ads. It gave us really good input into what was happening out there, as well as some input into our bylaws. We heard some pretty disturbing stories from people who are experiencing problems from ETS, and yet there is no way we can help them.

One example are the senior citizens who can't leave their apartment buildings because there's smoking in the halls, stairways, elevators, laundry rooms, recreation centres. They have to stay in their apartments if they want to breathe clean air. If the majority of the people on their board of directors are smokers, then they're not going to enact any policy in their building to try to curtail it.

#### 1210

The mother of two young children who's trying to find a place at the mall, after a busy day of shopping, to sit down and have an ice cream cone with them is unable to find a place to sit where she can't breathe environmental tobacco smoke. The food court at the mall is 100% smoking. The benches in the corridors at the malls have ashtrays attached to them and very often people are sitting there smoking, so it's very frustrating.

We heard from women, one of them pregnant, working in a small non-unionized manufacturing company. Their story is that 50% of line workers smoke during work, although they're not supposed to. Nobody bothers to enforce it. The only room where they can go and rest on their break is a lunchroom and it is just filled with tobacco smoke during breaks.

They've requested management to do something about this and they were met with the response, "Well, you girls should just take up smoking so you blend in with the other workers." Obviously, the Smoking in the Workplace Act is not effective because 25% of the floor space is not required to be in a discrete location and separately ventilated, so there is no place for these people to go.

Waitresses in local restaurants contacted us and told us how they feel physically sick from the smoke they inhale. They described how they cannot even wear their uniforms home because of the smell. Think of what their respiratory systems look like.

One local doughnut shop owner describes physical symptoms such as headaches, lethargy and frequent respiratory symptoms that he and his family experienced when they worked up to 12 hours a day in a smoke-filled environment. They actually had to change their clothes in their garage before entering their home. For them it became such a problem that they decided to take a real risk and they went smoke-free. They now run a successful smoke-free business, experiencing much more health and lower maintenance costs. Not only that, their doughnuts stay fresher much longer. Unfortunately, not all people are lucky to have this kind of choice.

We tried to address these people's concerns at the municipal level and you can see that we have a sample of our bylaw in the appendices. Our community consultation strongly supported our municipal proposals, but we did



not have the opportunity to report these results because of a noisy minority of influential business people who have the ear of city council members. The bylaw was deferred.

These issues must be addressed at the provincial level. The state of Michigan will soon implement restrictions such as a 50% limitation in smoking in restaurants. I ask why Ontario can't pass the same province-wide type of restriction.

A comprehensive provincial law avoids the confusion of having different smoking restriction standards from one municipality to another. We know that to gain compliance, legislation must be clear and unambiguous. A patchwork pattern of laws to protect the public from ETS is confusing, because it deals with different standards among the potential of 128 municipalities across the province. Ontario needs and deserves a consistent blanket of protection for its residents. This needs to be legislated by a body far removed from the inconsistencies of municipal politics.

As provincial representatives, we urge you: Do not fall into the trap of listening to those who solely view this as an economic issue. Designating retail stores, laundromats, hair salons as smoke-free public places is a very good start, but the public deserves more protection than this limited amount. We urge you to restrict smoking in all public places and to try to improve conditions in work sites.

This is not a rights issue. It is very much a health issue. We believe that the provincial government is empowered to deal with health issues. As I mentioned in my brief, people see this as an economic issue and a rights issue, but we firmly believe it is nothing but a health issue. With one of the goals of the Premier's Council on Health, Wellbeing and Social Justice being the elimination of ETS from public places and work sites by 1995, we feel the time to take action is right now.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I'd like to ask you about your appendix B, your bylaw regarding Windsor. Is that in process now?

**Ms Haugh:** Yes, it's in process now. It has been deferred by city council. We went to city council on January 17. We were optimistic we could pass it, but as I said, some few influential business people got to the councillors and it's been deferred for more consultation. We are not sure where it stands right now. It will come back before city council in the spring.

**Mrs O'Neill:** Is there quite a lobby to get it back on the agenda?

**Ms Haugh:** It is back on the agenda. It will be back in the spring. In April we hope to go back to city council again. In the meantime they're having more public consultation, and again my fear is it's going to be the noisy minority that will be heard.

**Mrs O'Neill:** It's amazing. I had no idea that there was any city in Ontario that had that many areas, public places, with 100%—

**Ms Haugh:** Smoking, yes.

**Mrs O'Neill:** It certainly seems to be out of step. I wish you well. I'm very pleased you brought us up to date on what's happening with such an informative chart.

**Mr Jim Wilson:** Thank you for your presentation. I would agree in particular with the latter part of your presentation, where you talk about the patchwork of bylaws. In fact, we had the restaurant association last week telling us that they're fed up too and that it's costing them a great deal of money, the retail sector and the restaurant sector, to try and conform, because a number of the calls they get to the association is, "What is the law in this municipality?" Of course, time is money in business.

They made a very good point and they challenged the government to come up with a province-wide piece of legislation. The government's response at that time was: "Don't bug us. We're the Ministry of Health, for goodness' sake, and we're not responsible for workplace legislation. That's the Ministry of Labour."

You have an opportunity now to try and convince the Health ministry, which doesn't mind picking on retailers and a bunch of other people, to give them one final message about the need for workplace legislation.

**Ms Haugh:** Thank you. Yes, we're trying.

**Mr Jim Wilson:** Keep up the good work.

**Mr Winninger:** I can certainly sympathize with your situation, having been to Windsor last week on another committee that heard fairly overwhelming support for another bill, apartments in houses, but there were people there from the municipality of Windsor suggesting that the city should have discretion in these kinds of matters.

Going to one of your local restaurants for lunch and not being able to escape the aroma of smoke, no matter where I sat, brought home to me that the fact that the city was not taking the initiative in this respect. I would ask you whether it's not appropriate in cases like this, where the province has already taken strong measures to deal with smoking in places like schools and health care centres and day care centres, that we need to bring our municipalities up to speed and at the same time continue to consult with the Ministry of Labour to deal with workplaces.

**Ms Haugh:** Yes.

**The Chair:** Thanks very much for coming before the committee today. We appreciate it.

SCOTT COULTER

**Mr Scott Coulter:** Good afternoon, Mr Chairman and honourable committee members. My name is Scott Coulter and I am an independent community pharmacist practising here in London.

I would like to begin by commending the provincial government on its goal of reducing tobacco consumption in Ontario by 50% by the turn of the century. It is legislation such as Bill 119, the Tobacco Control Act, that will make this goal one which is attainable.

As a pharmacist and an Ontario citizen, I support in full all of the initiatives contained in the new legislation. By preventing young people from starting to smoke, helping those who do smoke to quit and protecting the public from the dangers of secondhand smoke, Ontario will be a healthier province.

The views and recommendations that I will present to

you today will most likely not contain anything you have not already heard, but I hope I will be able to emphasize a few key issues. The particular portion of the legislation that I would like to concentrate on is the removal of tobacco products from all pharmacies within the province.

Community pharmacists face a constant dichotomy within their practice. As both health care professionals and retail business people, we are continuously involved in an ethical tug of war. It is the pharmacy's ability to maintain adequate profitability which directly influences its ability to provide necessary health care services to the surrounding community.

#### 1220

As a recent graduate in pharmacy, having received my licence in September 1993, my university education has provided me with some of the most up-to-date knowledge on health, disease and pharmaceutical care. Specifically, today's pharmacist is responsible for identifying patients who are experiencing drug-related health problems, solving those problems and in certain situations preventing these drug-related problems from occurring.

Pharmacists are on the front line as one of the most accessible health care professionals. They monitor patients' medications for possible drug interactions, advise other health care professionals on drug therapy, educate patients on both prescription and over-the-counter medications, as well as make both drug-related and non-drug-related recommendations with regard to the public's health.

With such an important emphasis on health in Ontario's more than 2,000 pharmacies, tobacco products have no place in these facilities.

Respiratory diseases such as emphysema, bronchitis and asthma, and lung cancer, heart disease, stroke and many other diseases may all be a result of or worsened by tobacco use. These are all diseases which result in significant morbidity and premature mortality. In fact, 20% of all adult deaths in Ontario may be directly attributed to smoking. People who suffer from these diseases rely on their pharmacy to provide them with the medication and advice they require to manage their condition and improve their lifestyle.

The best advice a pharmacist can give to those people who continue to smoke is to quit. Pharmacies which continue to sell tobacco products interfere with their pharmacists' ability to educate the public on the dangers of smoking. The sale of tobacco undermines the pharmacist's credibility as a health care provider. It is incompatible and unethical for pharmacy, as a health profession, to be involved in any way with the sale of tobacco.

The pharmacy profession did begin to respond to this issue. The Ontario Pharmacists' Association, which represents approximately 40% of the province's community pharmacists, positively acknowledges those pharmacies which have voluntarily ceased to sell tobacco. The Ontario College of Pharmacists, our governing body, also took the initiative in 1991 by requesting this legislation which would terminate the sale of tobacco products in every single Ontario pharmacy. The result would be the creation of a level playing field and a positive image for

the profession. Opponents to the removal of tobacco products from pharmacies have used many arguments. Many of these critics justify their position based on its economic impact. Citing pharmacy closings, reduction of services and job layoffs, many groups see no benefit to this portion of the legislation.

Although I cannot make predictions on the impact that this legislation will have on other pharmacies, I can share with you my own experience. I have the privilege of practising in a relatively small, tobacco-free, independent pharmacy which is owned by my father. He has been a licensed pharmacist in Ontario for more than 30 years and a pharmacist-owner for more than 20 years. In October 1989, he voluntarily removed tobacco products from his store. Although it did have a noticeable impact on cash flow and customer traffic, the overall effect on total sales was negligible. The positive publicity and consumer support surrounding his removal of tobacco at that time may actually have had a positive economic influence. There were no job losses and no reduction of services. The pharmacy remains an economically viable business.

While some pharmacies rely on their front-shop sales to subsidize their dispensary, in our pharmacy, more than 60% of our sales may be attributed to the dispensary of which more than 50% of our prescriptions are paid for by the Ontario drug benefit plan.

Pharmacists have argued that because nicotine is a drug it should only be available in a pharmacy. Others believe that pharmacists should be available to give those tobacco purchasers advice on the risks of smoking and on how to quit.

Unfortunately, in the majority of pharmacies, the pharmacist is in the rear of the store while the tobacco counter is at the front door. The hundreds of square feet separating the two makes it impossible for the pharmacist to have any impact on reducing tobacco consumption. Nicotine, which is a drug, is unlike any other drug found in a pharmacy. Its pharmacology has no beneficial effect on the human body. Even alcohol when consumed in moderation has been shown to produce positive health effects.

My recommendations to this committee are threefold:

First, as a progressive step forward for the practice of pharmacy in Ontario, ensure the passage of Bill 119, including the ban on the sale of tobacco in all pharmacies.

Second, make sure that the ban encompasses all pharmacy practices. That means removing tobacco products from all independent and chain pharmacies as well as all secondary pharmacy settings. Supermarkets and bargain department stores that wish to operate pharmacy departments within their stores should not be able to sell tobacco products anywhere within their stores.

Third, and finally, prohibiting the sale of tobacco products in pharmacies will simply shift the purchase from drug stores to convenience stores, gas stations and grocery stores. It does not appear that such a ban will significantly reduce tobacco consumption in Ontario. Therefore, I strongly recommend the provincial govern-



ment take further steps to limit the availability of tobacco products in the province. If they were restricted to government-controlled outlets similar to liquor and beer stores, I believe Ontario tobacco consumption would decline, especially by preventing young people from having access to the deadly product.

I thank you very much for giving me this opportunity to speak to you today.

**Mr McGuinty:** Thank you, Mr Coulter. First of all, I want to thank you for articulating the dichotomy, as it were, and how the successful business side of a pharmacy can enable people to carry on a mandate as a health care provider. I'd like you to tell me something about the business. I gathered that when you stopped selling cigarettes in a pharmacy over a period of time, you would make up for that.

**Mr Coulter:** Actually, when my dad became sole owner of the pharmacy in October 1989, we moved next door, and in the move no tobacco products came with us. So literally on the opening Monday of our new business year we were tobacco-free. By the end of that fiscal year our sales were up over the year before without tobacco products being included.

**Mr McGuinty:** I gather that if you're going to make it up, if you're going to get rid of cigarettes at a pharmacy, you're not going to make it up in additional prescriptions; you're going to make it up elsewhere.

**Mr Coulter:** The profit margin on cigarettes is not that high, especially in a competitive market as now versus then. Really what it was doing was providing cash flow. The product wasn't staying in the store for any period of time. It was turning over and it was producing cash to use in the business. Really, it wasn't creating a great profit margin within the store; it was providing cash.

**Mr McGuinty:** We've heard that cigarette sales account for about 8% of total sales in pharmacies as an average. Why couldn't we ban tobacco sales in any store in this province which has sales in that range, on the assumption that they could make up for it? The problem I have is that the difficulty is assuming they can make up for it, if it's done in one fell swoop.

**Mr Coulter:** A pharmacy, like most retail businesses, is in a competitive market. If you can't compete given the circumstances that the level playing field will create, then maybe you're in a position where you don't need to be. I truly believe that with 14 of the 20 independent community pharmacies in London not carrying tobacco products, and no record of a closing of one of those stores, it is possible to remove the product from all pharmacies without seeing a significant closure rate.

**Mr Jim Wilson:** Thank you for your very articulate presentation to us this morning. The point you make about their being very little profit in tobacco sales is exactly the point made by even those pharmacists who want to retain the right to sell tobacco. They tell us that in and of themselves tobacco products are very low profit—it's about a 4.4% margin—but about three studies now have shown that for every dollar of tobacco sales, the spinoff is an additional 39 cents in other sales; for

instance, picking up toothpaste, a toothbrush, a chocolate bar, or whatever. That's their point. They have not actually, as far as I've heard, made the point that tobacco in itself is profitable and that's why they want to sell it. It's simply a retail argument, and you've made that argument very well.

You've also pointed out that removing the sale of tobacco from pharmacies will likely have little or no effect on overall consumption of tobacco products, and I appreciate your honesty there. The opposite argument that's made, opposite to removing the sale of tobacco profits from pharmacies, is that pharmacies sell a number of poisons, so if you really want to have an effect on consumption and you really want to limit access to the purchasing of tobacco products, why not take it out of all other retail sectors and move it behind the counter and into the pharmacy?

**Mr Coulter:** And treat it as a controlled substance?

**Mr Jim Wilson:** And treat it as a controlled substance.

**Mr Coulter:** If it's behind the counter like all schedule C drugs are in this province and it's the pharmacists' responsibility to sell, then I can't come to grips with that idea and the logic behind that point. As I point out, when you walk into certain drugstores the distance that separates the pharmacist from the tobacco counter makes him have no impact whatsoever right now on that sale.

1230

**Mr Jim Wilson:** But if you put it behind the counter and made them solely responsible, because they have testified that they are very responsible merchants and they are health professionals.

**Mr Coulter:** The arguments—I've even heard this morning how young people under the age of 18 can purchase tobacco products in pharmacies—just go to show that it isn't the pharmacist who's even involved, except for the pharmacist-owner, in controlling that sale. It is the cashiers who are working on the Friday nights, Saturdays, weekends.

**Mr Jim Wilson:** It's essentially at the retail end of the store.

**Mr Coulter:** Exactly.

**Mrs Haslam:** I don't have many questions because I found your presentation spot on, as a colleague of mine would say. You've answered many of the questions. I think ultimately the question that we have to address in this committee and in this questioning for this legislation is, are you a pharmacist or are you a retailer? Are you a health practitioner or are you a retailer? What would your answer be?

**Mr Coulter:** With economic times and budget restraints, and provincial fiscal policy the way it is, it is not possible right now in this province to operate—it would be nice to be able to operate solely as a pharmacy, counselling patients, supplying medication, dealing with their problems. Unfortunately, it is not possible to do that right now with the rollbacks and the lack of funds that are available through dispensing prescriptions.

Unfortunately, it is truly a dichotomy and it's a matter of drawing a line where you will stand as a retailer and



as a businessperson. For those pharmacists who have removed tobacco products from their stores, they are drawing a line on the professional side rather than on the retail side.

**The Chair:** Thank you very much, Mr Coulter, for coming before the committee today.

#### WINDSOR-ESSEX COUNTY HEALTH UNIT

**Dr Allen Heimann:** Good morning. My name is Dr Allen Heimann. I am the medical officer of health for the city of Windsor, county of Essex. With me this morning is Mr Paul McDonald, who is the director of the health promotion and healthy lifestyles division of the health unit. I will be making the presentation. Mr McDonald will be able to assist me with background material during the question period.

Thank you very much for this opportunity to present to you the health concerns of the residents of Windsor-Essex. It is particularly important that I am here today, because what we're looking at this month is a watershed in the efforts in the fight against tobacco, at the city level, at the provincial level and at the federal level.

I would like to begin by commending the current provincial government for its public stand against the reduction in the tobacco tax and for introducing this important piece of legislation. I applaud the two opposition parties for supporting it at the standing committee.

While Bill 119 has many worthy components, including the protection of the public from environmental tobacco smoke, I wish to focus my remarks today on the significance of the bill on our young people. In Windsor-Essex, 200 of our youth take up the deadly habit of tobacco use every month. Unless they quit, one third of them will die prematurely and suffer significant disability before they do so.

We need strong, effective, comprehensive strategies to prevent this from happening. The Windsor-Essex County Health Unit is doing everything it can to make the public aware of the hazards of tobacco. But research clearly shows that education is not enough. Studies demonstrate that education programs only work when combined with strong public policy. Tobacco use hinges on a multiplicity of complicated psychological, social and environmental factors. We must do everything we can to create an environment as well as the knowledge that limits minors' access to tobacco.

Strong action against tobacco is particularly necessary at this time, with the impending threat of reduced taxes by the federal government.

I believe that Bill 119 represents an excellent beginning and will surely help to protect the health of our population, particularly that of our youth. However, in order truly to have an impact on large numbers of youth who take up smoking, I would recommend some additional amendments to strengthen Bill 119. My suggestions are in regard to licensing, point-of-sale displays, plain packaging and possession.

**Licensing:** Enforcement and compliance among tobacco vendors are going to be important issues in contributing to the effectiveness of this legislation. One recent study showed that up to 80% of current youth are

supplied tobacco through retail stores. Bill 119 provides for statutory prohibition of sales to minors under the age of 19 with a possible six-month prohibition on selling tobacco after the second conviction.

I strongly recommend that you take this one step further. Licensing of vendors with a substantial licence fee would generate the revenue necessary to allow for a comprehensive monitoring and enforcement system throughout the province. Moreover, the threat of rescinding a licence is far more of a deterrent than a fine to retailers who may be tempted to sell tobacco to minors.

This strategy would also assist with the illegal sale of smuggled cigarettes since documentation by wholesalers and retailers of deliveries, inventory and sales would be part of the licensing requirement. The illegal sale of smuggled tobacco would constitute an automatic revocation of a tobacco vendor's licence.

**Point-of-sale display of tobacco products:** Adequate signage with health warnings and elimination of point-of-sale displays are important components that would make this legislation more effective. Although tobacco advertising is banned in Canada, the high visibility of tobacco products in prominent store locations provides a temptation that youth are not able to resist. For example, a wide variety of retailers currently place tobacco displays in a manner that is eye level to 11-, 12- and 13-year-old children. Requiring tobacco vendors to store products out of sight would reduce the coercive pressure currently being placed on youth to smoke.

**Plain packaging:** On a similar note, the colourful and alluring packaging in which tobacco is sold is made to be irresistible to youth as well as to other consumers. This committee cannot ignore the recent study of the University of Toronto centre for health promotion that demonstrated that the appeal of smoking is reduced by plain packages. This study supports previous research on positive cigarette imagery associated with packaging.

These dramatic and unique steps are essential if we are to have any chance of reducing the carnage caused by tobacco use in this province. Moreover, these steps are clearly justified given that tobacco itself is already unique; namely, that it is the only legal product sold in Canada that, when used according to manufacturers' directions, kills.

**Possession:** Tobacco is responsible for over 500 deaths a year in Essex county. Its distribution must be controlled like any other controlled substance in this province. We know that distribution entails more than just sales to minors. Bill 119 does nothing to address the issue of possession of tobacco products, including chewing tobacco, by minors.

I believe that youth need to be accountable for their actions and that society, through legislation, needs to reflect that accountability. In order to be comprehensive, the legislation needs to include a sanction on the possession of tobacco by minors, even if it is merely a confiscation of the product.

#### 1240

I invite members of this committee to drive by some of our local schools before classes start in the morning to

watch groups of students huddle together engaging in this dangerous habit. Yet we are unable to stop it.

Qualitative studies with youth indicate that making possession illegal is an important preventive strategy. Our attempts to educate youth are continually being undermined because teens place their faith in governments. They repeatedly claim that if tobacco is as bad as educators claim, then surely the government would ban it. Given that tobacco is the greatest single identifiable threat to health in Ontario today, I call upon you to justify the faith of our youth in their government by taking the necessary steps to protect their health.

In conclusion, let me repeat my congratulations for bringing this bill forward. However, as a person charged with the responsibility of protecting the health of the residents of Windsor-Essex, I urge you to give serious consideration to my suggested augmentations. No amount of effort at the provincial level or collective work of health promotion agencies can overcome the lack of a comprehensive provincial tobacco strategy.

I thank you very much for your consideration and I welcome your questions and comments.

**Mrs Cunningham:** Thank you very much, and congratulations. You are the first group to come forward with such a strong position on responsibility for young people. I have to tell you that I've worked in this city for some 20 years on this issue, and it's always been the position of our local school board that we needed more clout in dealing with our young people. Taking a look at the smoking patios of schools, there are very few students who are smoking who aren't under the age of 18, smoking, right in front of the eyes of their teachers, and it's illegal to purchase it. What can we say? So thank you very much.

There was a model brought to the attention of the committee, we're not sure of the state, but they put the responsibility on both sides. In one of the municipalities, retailers must be licensed to sell the product, and there's also a fine of \$25. In other words, young people are ticketed under a certain age and they have to pay their ticket.

In this environment in Ontario, at least during the public hearings, we haven't had your position stated very often, and it's often not the position of some of the groups that we would expect it to be. I was part of those groups myself where we did want to change attitudes. But I think you're right: The time has come and we have to accept responsibility. I'm wondering if you're aware of any other information in this regard that could help the committee in looking at these kinds of models, in North America or elsewhere.

**Dr Heimann:** I'm not currently aware, but if there are other jurisdictions which have that licensing, this is something we are currently looking at as a way of strengthening our local bylaws. This was referred to before, and this is something we are currently researching. We do think that licensing is by far the best way of significantly controlling this very serious health problem.

**Mrs Cunningham:** Thank you very much for an important presentation today.

**Mrs Haslam:** My colleague mentions changing attitudes. How much work do you do within the education system? The reason I ask is that it says, "In Essex county, 200 of our youth take up the deadly habit of tobacco." We've had presentations over the last week that say 3,000 young people a month. If you average that out, it's 6% of a national average, 6% of the young people on a national level who start smoking, who start smoking in the Windsor-Essex county area. What kind of educational process are you involved in in this area?

**Dr Heimann:** Along with the school boards, along with the coalition, of which Ms Haugh, who just made her presentation, is the president, we have a comprehensive strategy to try to provide education, to try to strengthen peer pressure against smoking, but we have the difficulty of being up against one of the most sophisticated and powerful lobbies and indirect advertising systems in North America.

**Mrs Haslam:** I agree with you, and that's something I've been talking about as we look at this. Do the young people realize that? Is that ever part of your message, "You are being used by marketers, you are being targeted, you are the guinea pigs for this type of advertising campaign"? Are the youth aware of that? Is that part of your program in the education system?

**Dr Heimann:** Yes, it is.

**Mrs Haslam:** I ask because it makes us question what will get to youth, as always.

Two more things: On page 6, you say that youth proclaim "that if tobacco was bad as educators claim, then surely the government would ban it." Have you got empirical data that says that is something they say, or is that a copout? Is that an anecdotal way of looking at it?

**Dr Heimann:** We have studies and surveys which show that. There is no question that as far as youth go, it is a rationalization. We are certainly not looking at calling for the banning of tobacco, but what we're looking for is a strengthened regulatory, restricted environment which will show youth that as the majority of Canadians, the majority of Ontarians have shown, smoking is not the normal way, that the majority of Ontarians do not smoke and that it is also socially unacceptable. That's what we need, to send that message through this type of legislation; not banning, but sending a very strong message that it is socially unacceptable and irresponsible.

**Mrs Haslam:** Going from the social aspects of the problem to a more pragmatic way, you mention going one step further to licensing. I think some of the concerns would be the timing of this for small business people, for the convenience stores. Do you feel that the licensing aspect that you are recommending would be much better than the present ticketing model that is now in place within the legislation? In what way would it be better? Do you think this is the right time to bring that extra step in?

**Dr Heimann:** Yes, I think it would be better because it would be uniform. It also would represent a clear statement that selling tobacco is something which is a right, and that this right carries certain responsibilities. If



manufacturers and retailers do not carry out their responsibilities, then their right to sell that product would be restricted.

We could look at graded fees depending on the size of the retailer, but the idea and the message that we want to send are that selling tobacco is a right, and that right carries responsibilities.

**Mr McGuinty:** Thank you both very much for your presentation. I particularly appreciated the comments regarding possession. I think they present a realistic approach and help make the approach that the government is taking to this terrible problem more comprehensive. As I was indicating to an earlier presenter, I think that to see young people merely as victims is unrealistic.

By and large, we have, over the years, been focussing constantly on rights at the expense of responsibilities, and I think this kind of provision would give an important weapon for parents' use in their arsenal.

I still think it's meaningful to be able to tell kids, "And by the way, son, it's against the law." I think it's important for teachers to be able to tell a class, "And by the way, it's against the law." I think it's important for the medical profession, the health care deliverers throughout the province to be able to say, "And by the way, kids, it's against the law." Right now we're telling them—we do it implicitly—"Really, nothing's going to happen to you if you go ahead and continue to smoke." We're making all kinds of money off it. We're supporting an entire industry. We're feeding families. We're putting kids through school.

If we're sending a mixed message, I think this helps focus the message to make them understand, "It's a serious issue, so serious for us that we're going to make it illegal for you to get hooked." I want to thank you for that.

**Mr Larry O'Connor (Durham-York):** You support the statutory prohibition as outlined in the legislation, do you not?

**Dr Heimann:** The statutory prohibition?

**Mr O'Connor:** The prohibition that is in the legislation before us.

**Mrs Haslam:** Versus licensing.

**Mr O'Connor:** No, it's not a "versus." We have a statutory prohibition in the legislation. You do support that element of the legislation. You'll find it around page 8, I believe.

**Dr Heimann:** The statutory prohibition on the sale to minors?

**Mr O'Connor:** Right.

**Dr Heimann:** Yes, absolutely. We strongly support and commend the government and the opposition parties for bringing this legislation forward. We would very much like to see this legislation strengthened, but certainly we support what has been brought forward. We would certainly hope, however, that it could be made stronger.

**The Chair:** Thank you both very much for coming before the committee. We will recess for lunch and reconvene here at 2 o'clock sharp.

*The committee recessed from 1252 to 1356.*

#### LONDON COUNCIL OF HOME AND SCHOOL ASSOCIATIONS

**Ms Janet Andruchow:** My name is Janet Andruchow. I'm the president of the London Council of Home and School Associations. I represent 43 individual home and school associations, both at the elementary and secondary levels, in the city of London, with a membership of about 2,700 people.

On behalf of the London council, I would like to offer our thanks to the government and the two opposition parties for their introduction and support of this legislation through second reading. We are not authorities on the use of tobacco or its causes and effects. What we are is a group of concerned parents, mostly parents. We have membership with educators and any persons who are interested in the welfare of students.

The Ontario Federation of Home and School Associations is a supporting member of the Ontario Campaign for Action on Tobacco and the London council of associations is a member of the London-Middlesex Council for a Tobacco-Free Community.

I want to summarize a few points we have in the brief we gave you, and those are the parts of the bill that pertain particularly to the London Council of Home and School Associations.

Section 2 describes the application of Bill 119, referring to "processed or unprocessed form that may be smoked, inhaled or chewed, including snuff." We support this, as it covers all forms of tobacco. Many of our children emulate their sports heroes, watching baseball players regularly using spitting or chewing tobacco, which causes us concern that this will be the next stage to tobacco.

One thing we noticed in this existing legislation is that there needs to be effective enforcement as a deterrent to the selling of tobacco. Perhaps regulations should reflect the same wording that is presented under the Liquor Licence Act, as the phrase "appears to be" allows a lot of latitude. Bill 119 must contain some kind of requirement that will make it extremely uncomfortable to sell to minors, either very high financial penalties or removal of their licence.

We appreciate the inclusion of health warnings. We believe that education is as important as restrictions.

We certainly support subsection 7(1). Vending machines make it too easy for students to circumvent the regulation of having to be over 19 to purchase tobacco products.

There is only one area in this whole bill that really causes us concern, and that's section 9, paragraph 2. Our concern mostly stems from, "No person shall smoke tobacco or hold lighted tobacco in any of the following places.... A school, post-secondary educational institution or private vocational school." We would prefer that this section specifically cover all forms of tobacco, not just smoked or lighted, and secondly, that it refer to the buildings and property of schools.

At the 1993 annual conference of the Ontario Federation of Home and School Associations the membership passed the following resolution, "That there be zero



tolerance towards smoking in the buildings and on the property of all Ontario public schools."

This section also eliminates a lot of places that we would prefer to see included as being restricted for smoking. The places designated leave a large number of public places eliminated. Environmental tobacco smoke is as serious as the physical act of smoking. We would recommend that this section be revised to prohibit smoking in all public places.

In conclusion, I thank you very much for the opportunity to be here today. We certainly hope to see this bill go past through third reading.

**Mr Winninger:** Thank you for your presentation. I gather that the London Council of Home and School Associations has been quite active in opposing cigarettes in the hands of minors. I see a whole list of initiatives that you've supported to date. Is there any strategy the council is going to take in regard to helping us, as government, to educate minors and their parents around the problems with tobacco consumption?

**Ms Andruchow:** We basically work towards education, and we totally support the London-Middlesex Council for a Tobacco-Free Community by promoting education. We are also right now petitioning, with the help of the secondary school principals' council, to eliminate what you call "smoking pits" in the secondary schools. By education, we feel we will eventually succeed.

**Mr Winninger:** Are you doing any lobbying with regard to businesses that may presently be dispensing cigarettes to minors? We heard this morning, and I don't know if you were here, from a young student from St Thomas who was able to purchase cigarettes at an extremely tender age without any difficulty.

**Ms Andruchow:** We haven't done any direct lobbying, but I agree with you. I asked a student to purchase cigarettes for me. Now, because last week was exam week, they didn't manage to do it, but they seemed to think that was no problem, particularly around the secondary schools in London. The only way we'll ever stop that would be by educating the students themselves.

**Mr Winninger:** I think my colleague has a question.

**Mr Kimble Sutherland (Oxford):** I just wanted to know, is that purchasing from normal retailers or was this purchasing from someone who may have been hanging around the school with a gym bag or something, with illegal cigarettes?

**Ms Andruchow:** This was purchasing from a store.

**Mrs Cunningham:** I didn't have the chance to welcome my colleagues to London in the beginning, but I think this is an important time to do that. Because Janet's here today, if you take a look at the second page, in the beginning the work of the home and school associations in 1965, before it was even—what should I say? It wasn't very popular to take the stands the home and school associations took with reference to cigarette smoking and advertising and the promotion of health.

I think it's an opportunity to thank the school community, and certainly here in London we do often, and the Ontario Federation of Home and School Associations

for their leadership in this issue, because without them I don't think we would have got as far as we have, at least in our local municipalities.

I just wondered, from the local home and school associations' point of view, if you have had any discussions with our secondary schools recently, because I haven't been made aware of any action that you've taken with the problem of smoking in the schools. Are there any enforcement practices here in London that we could use as an example across the province? What is the rule in our London secondary schools now?

**Ms Andruchow:** Right now they have what they term "smoking pits," but the secondary schools' council has just, within the last month, come across to support us. They tried a couple of years ago to take them away and all it ended up doing was causing the neighbours around the schools—I believe that John Paul II, which is the brand-new Catholic school, has banned smoking on its property. That has caused a few little fluctuations of neighbourhoods being concerned. We're really working on a phase-in program, so that you remove the students out to the farthest corner of the property where it's the windiest and coldest, that type of strategy.

**Mrs Cunningham:** The practical application we're both talking about here is that even if you were to say it was illegal, you still have the problem without the ability to enforce it. You can understand where it's coming from. We were talking about this in one of the secondary schools last week, where the students themselves said exactly that. "Let's have a shed or something out in the corner of the school grounds or a snow hut," they were saying that particular week for the students who were smoking. Thanks very much for your leadership here.

**The Chair:** Thank you very much for coming before the committee this afternoon.

#### CANADIAN CANCER SOCIETY, SOUTHWESTERN ONTARIO REGION

**Ms Susan Cornish:** My name is Susan Cornish and with me is Sarah Fielding. I'm pleased to represent the southwestern regional office of the Canadian Cancer Society and I'd like to commend the social development committee on Bill 119 for conducting these hearings and thank them for inviting the cancer society to participate.

I would also like to commend the government for its leadership with regard to the recent tax issues. I am here as the health promotion chair of the London-Middlesex unit of the Canadian Cancer Society, as a professional in the health care field, as the mother of a 12-year-old and a 15-year-old, and as a member of the community.

As a volunteer with the cancer society, I feel personally committed to the society's mission to eradicate cancer and to enhance the quality of life of people living with cancer.

I am delighted to have with me Sarah Fielding. Sarah is a 15-year-old student at Clarke Road Secondary School in London who has volunteered to help impress upon this committee the importance of the legislation. While Sarah does not smoke herself, she has many friends and acquaintances who do smoke. She has learned from them how difficult it is to quit once you are addicted. Many

want to, but can't. As an active participant in school activities, Rangers and Junior Achievement, Sarah is gaining experience that is preparing her for a satisfying and productive life. We want all our children to have the opportunity to realize their potential. Tobacco use may well limit that opportunity.

To prepare for today's presentation, I outlined several possible questions for Sarah to consider so that she might have the opportunity to prepare her responses.

Sarah, when I asked you to participate in the presentation, what was your reason for agreeing?

**Ms Sarah Fielding:** I decided that it would be very important to give out a message for children that smoking's wrong and that this bill would be very good for that.

**Ms Cornish:** Do many of your friends smoke?

**Ms Fielding:** Yes, quite a few of my friends smoke.

**Ms Cornish:** Among your friends, do more boys or girls smoke?

**Ms Fielding:** I'd have to say it was a lot more girls than boys.

**Ms Cornish:** What was the reason your friends started to smoke?

**Ms Fielding:** A lot of them started in public school, grades 7 and 8. I think they thought that if they started smoking, they'd be popular and they'd be cool and that this would continue on to high school, because especially for a lot of kids, grade 9 is a very insecure year, and if they can be popular in grade 9, they'll continue to be popular throughout high school.

**Ms Cornish:** Have many of them tried to quit?

**Ms Fielding:** All of my friends have tried to quit at one time or another and I don't think any of them have been successful.

**Ms Cornish:** Do you think your friends who smoke took into consideration the nature of the risk and the magnitude of the danger associated with the use of tobacco products?

**Ms Fielding:** I don't think they really considered that. I think they thought it was just to be cool, and I don't think they thought about life down the road, cancer and things like that.

**Ms Cornish:** Have you ever considered trying cigarettes yourself?

**Ms Fielding:** I've been very curious because a lot of my friends smoke, and when I'm around them it's just the curiosity of what it tastes like, what it's like and what the attraction there is.

1410

**Ms Cornish:** How do you think your parents feel about young people smoking?

**Ms Fielding:** They're very much against it. I know that they think it's a waste of money and a waste of time and that it's bad for the children because it will affect their health in later years.

**Ms Cornish:** What effect do you think plain packaging would have on the decision of young people to start smoking?

**Ms Fielding:** I think a plainer package might bore them. They might not decide which brand they want. They wouldn't care what brand they smoked because of the plainer packaging. I don't really think that it would make them want to smoke any more.

**Ms Cornish:** Do you think smokers should be informed on the packaging of the seriousness of diseases that could be contracted from tobacco?

**Ms Fielding:** I think that's very important because a lot of them aren't educated enough on what it is. I think that if it states what's wrong on the outside in large letters, what can happen to them—I think that even including a pamphlet on the inside, whether or not they read it, it's there and that gives them the opportunity to educate themselves.

**Ms Cornish:** Have you been with your friends when they have purchased cigarettes?

**Ms Fielding:** Yes, I have. I've been with friends when they've gone into variety stores and they've purchased them. They've never been asked or looked at strangely or anything like that. Maybe if the bill did go through, carding them might be a good way to stop them from doing it, because they don't get looked at twice.

**Ms Cornish:** Besides variety stores, where else have you been?

**Ms Fielding:** Gas stations too. Those are the only two places, I think, that they've ever bought them when I've been with them.

**Ms Cornish:** Did you find it strange that they weren't asked to provide proof of age?

**Ms Fielding:** I think so, because I don't think that many of them look 18. They walked in and bought them just like that. There was no discussion about it, no argument by the store owners.

**Ms Cornish:** Do you think tobacco products should be sold in pharmacies?

**Ms Fielding:** I think absolutely that they should not be at all, because a place that is supposed to be helping us improve our health shouldn't be selling something that hinders health.

**Ms Cornish:** Why do you feel it's important to prevent young people from smoking?

**Ms Fielding:** It's very important because at a young age they might not realize what effects it's going to have on them later on in life, cancer and other diseases, and how bad it is for them. I don't think they realize that at a young age, and if you can educate them enough, then they'll realize that it's more important down the road not to start smoking at all.

**Ms Cornish:** I spoke with a friend of mine here in London whose father died of lung cancer due to smoking cigarettes. His initial reaction was one of anger. This disease was preventable. It resulted from a decision to smoke made before we knew the potential consequences. We now know the harm that can be done. We must do whatever we can to help our children make the right choice. We want other kids to have the chances that Sarah will have. We want other children to realize their potential.



This legislation will help give kids a chance not to become a cancer statistic.

**Mr Jim Wilson:** Thank you very much for your presentation. I appreciated the questions posed to Sarah and your responses, Sarah. I'm going to add to that list. Do you think we'd send a stronger message to your friends, your peers, if we simply said that smoking cigarettes under the age of 19 or being in the possession of cigarettes under the age of 19 is illegal?

**Ms Fielding:** Maybe. I'm not exactly sure. If it was really stressed and they realized that there was a punishment of some sort or that they would be in trouble with the law, it might make them at least consider it twice.

**Mr Jim Wilson:** When your friends buy cigarettes at the local corner store or wherever, are they aware that the person selling them those cigarettes could currently be subject to a fine, that the retailer takes the blame and yet they get off scot-free? There's no penalty for them buying cigarettes at the local Becker's store under age, essentially.

**Ms Fielding:** I don't really think they're very concerned about their actions. I think that they think it is their responsibility to make sure they are of age, and if they don't card them or anything like that or ask for identification of their age, then it's the owner's responsibility to do that.

**Mr Jim Wilson:** Would all of your friends be aware that it's illegal to consume alcohol or to drink under the age of 19?

**Ms Fielding:** I'm quite aware that they do think that.

**Mr Jim Wilson:** They would be aware of that.

**Ms Fielding:** That's for sure.

**Mrs Haslam:** On page 4 of your submission, you talk about section 3. You want to look at the requirement of the proof of age section. You seem to have a concern around the wording "appearing to be less than 19 years old." You believe there should be something additional to that. I wondered if you would tell me what you're recommending as a strengthener in that particular section, "should not be contingent on the purchaser appearing to be less than 19 years old."

**Ms Cornish:** As Sarah was mentioning, some sort of identification, not just the vendor looking at the person and saying: "This person looks to be 19 years old. I will sell him cigarettes."

**Mrs Haslam:** So a stricter recommendation that ID must be presented and should be indicated by the proof of age card or age of majority card.

On the next section, when you talk about how the definition of "pharmacy" should be clearly stated in the legislation, are you talking about separate premises with a separate entrance, rather than something within a larger department store? Do you want it toned up or firmed up in that definition?

**Ms Cornish:** Yes, it should be.

**Mrs Haslam:** You talk about how the sale of kiddie packs, of packages less than 20 cigarettes, must be prohibited. Would you be suggesting a different level of fines for vendors or for retailers who are selling kiddie

packs or individual cigarettes? If you go in and find a retailer selling to a minor, they're charged and they're ticketed, according to the proposed legislation. On their second ticketing, they would lose the privilege of selling tobacco. They wouldn't even be allowed to have tobacco on their premises. If it was discovered that in that sale it was individuals or kiddie packs, would you recommend stronger fines, a different level of fines or the same? Whether you see this as more detrimental is what I'm wondering.

**Ms Cornish:** I really don't have a response to that, but I can certainly get back to you in writing.

**Mrs Haslam:** I'd like to ask one quick question. I'm quite concerned about the number of girls versus the number of young boys who smoke. I've always asked why. Why do we think the young girls are more prevalent in starting smoking than others? I know that last week was awareness of eating disorder week and I know that some young women feel that tobacco eases their appetite. It's part of another problem. Besides that problem, what would you think would be another cause for young women starting to smoke?

**Ms Fielding:** I think it's their friends. They think they'll be popular in high school. I think girls are more concerned with popularity than boys are when they get to high school age. I think it's insecurity too. If they're insecure with themselves, they want something to hold on to, to grasp, that will make them popular. They feel prettier when they're doing it. I'm sure they see it—

**Mrs Haslam:** He's telling me I'm out of time for questions.

**The Chair:** Sorry. I'm the heavy.

**Ms Fielding:** I think it's just a lot to do with popularity and their insecurity about themselves.

**Mrs Haslam:** The pressure is on.

**The Chair:** Thank you both very much for coming before the committee this afternoon. I'm sorry we don't have more time.

SID STEINBERG  
FRANCIS MOKENELA

**Mr Sid Steinberg:** My name is Sid Steinberg and I'm accompanied today by Francis Mokenela. We apologize for not having copies of our presentation, but we will hand in our speech and our visuals later on, should you wish.

We are both licensed pharmacists in the province of Ontario. I own and operate the Shoppers Drug Mart pharmacy located at Sherwood Forest Mall here in London on Wonderland Road, which is open 15 hours a day, from 9 in the morning till midnight. Mr Mokenela is the pharmacist-manager at the Ultra Mart pharmacy, which is owned by A&P, located at Commissioners and Wonderland, also here in London.

We have both followed the hearings of your committee, and in the short time available to us we wanted to bring you a different perspective on the issues. We have all heard an awful lot about the health issues. I'm sure everybody's well up to speed on that. We're going to talk from a different slant today.



A lot of the discussion your committee has heard has focused on the nature and the role of a pharmacy. Some members of your committee have stated that pharmacists must decide whether they are health care professionals or retailers. Many pharmacists have answered that they are both. The inability to understand the diversity of the industry is reflected not only in the questions that have been asked of pharmacists, but in the legislation itself.

#### 1420

In paragraph 4(2)9, the bill seeks to define "pharmacy" and "retail establishment." So that you can fully appreciate the complexity of the issue, we would like to use these visuals to help you understand. We sincerely hope that by showing you these blueprints and photos, you will realize that pharmacy has many different formats. We'll leave these here if you wish to have a look at them and pass them around. I know it's going to be a little difficult for everybody to see at close hand what we're talking about. Francis, do you want to get the first one of Woolco? That's only one half; here comes the other half.

This is a typical Woolco store. It is over 100,000 square feet. It's about the size of two football fields. You can see at the bottom right where it's yellowed. That is the pharmacy. The tobacco kiosk that sells tobacco is way up at the top, at the other end. Between the pharmacy area and the tobacco area are about 30 different departments, selling a diverse choice of merchandise.

This is my Shoppers Drug Mart. It's about 7,500 square feet, and you can see the dispensary at the back of the store. This is the back of the store, actually. The checkout, where the tobacco is sold, is about 100 feet towards the front of the store, near the exit to the mall. It's certainly nowhere near our dispensary where people are picking up prescriptions.

We also have a floor area plan of a typical Shoppers Drug Mart as well, which is very much like mine. The dispensary is back here and the tobacco is sold way over here. They're all set up very similarly.

This is a typical Ultra Mart store. It's kind of a small version of their floor plan, but I think that store is somewhere in the neighbourhood of 80,000 square feet. Perhaps my colleague Mr Francis Mokenela, having worked for them, can describe the layout of this store to you.

**Mr Francis Mokenela:** The Ultra Mart is an 80,000-square-foot complex which has different departments within it. The courtesy counter is over here, which is the front of the store, and this is where the tobacco is sold. Here is the pharmacy, right at the back end of the store. To get from the tobacco to the pharmacy, you have to go through the health and beauty department, with shelves standing as high as 10 to 12 feet, blocking the pharmacy from the front of the store. There is also 300 feet of distance between the pharmacy and the tobacco.

In an Ultra Mart concept, the dispensary or the pharmacy operates as a separate, independent entity within the supermarket. My authority and responsibility are restricted only to the dispensary. I have nothing to do with the sale of tobacco.

Here is a blueprint of a Loblaw's, one of our competi-

tors. Here is the pharmacy and here is the tobacco area. The Loblaw's is about the same size as the Ultra Mart and carries about the same type of merchandise mix as we do.

**Mr Steinberg:** At the completely opposite end of the spectrum from these kinds of stores are the small, independent community pharmacies like the IDA which I have in these photos. This drugstore is about 2,500 square feet, which is probably about the size of this room. As you can see, this drugstore sells a variety of products, but it obviously doesn't have the variety or depth of merchandise of the stores we have just described.

The dispensary is right down at the back of the store and we have several aisles of merchandise located in the rest of the store. The main thing we want to show is that the pharmacy is way at the back of the store and all the front-shop merchandise is located out front of course. This is their checkout, down at the front.

Lastly, there are many pharmacies located in medical buildings, as in this photo, which do not compete with regular retailers. As you can see, this is the dispensary on the right-hand side here. They carry very little front-shop merchandise and probably no tobacco at all. That's their operation. There is a picture here of the entrance, which is a small door, showing the dispensary area and the few medicinal ingredients they sell out front. We can pass this around as well.

This pharmacy does not sell tobacco, most probably never did sell it and the sale of tobacco in this store is not an issue. As a matter of fact, when we went in to take the pictures in this store, the pharmacist owner told me that he does not sell tobacco but that in his opinion it should be a voluntary issue.

**Mr Mokenela:** As I explained earlier, my pharmacy is one of several other departments in the total complex. I have no authority over the store as a whole and my responsibility extends only to the dispensary. In the event that my company is put in a position where it has to choose between operating a pharmacy or selling tobacco, I expect that the decision will be made based on the profitability and the cash flow generated by tobacco versus pharmacy.

If the intent of your legislation is to force A&P and others like ourselves to elect between operating a pharmacy or selling tobacco, I'll be very honest and frank with you: I believe that with the declining margins in pharmacy and because of the government ODB cutbacks, the consequences will be very detrimental to me. They will likely choose tobacco over pharmacy and that means I'll lose my job. It also means that many of our patients who have come to rely on my pharmacy and my professional service at the Ultra Mart will be forced to go elsewhere. Surely this cannot be the real intention of this legislation.

**Mr Steinberg:** That is why your legislation is so unfair and discriminatory. You are attempting to define all pharmacists the same, which we clearly are not. In your endeavour to do so, you are going to force some retailers to make the painful decision to close down the pharmacy or to stop selling tobacco. In the context of the retail environment we have shown you, it clearly makes

no sense whatsoever. By the way, that decision will have to be made in approximately 151 pharmacies located in establishments exactly like Woolco, Zellers, K mart, Loblaw's and A&P, and it will potentially affect the livelihood of almost 400 pharmacists. Your legislation will take away my ability to be a pharmacist as well as a retailer. In the case of Francis, your legislation could potentially take away both his pharmacy and his livelihood, and in particular, it will be extremely unfair because, as a pharmacist, he is not the one making the decision whether or not to carry tobacco.

As we understand it, the intention of this legislation is to prevent young people from smoking. We both share that objective. But in the final analysis, you will not achieve it by doing what you are about to do. Do you really think that if Francis's employer closes the pharmacy at the Ultra Mart or if I remove tobacco from my store, any juvenile will smoke one less cigarette?

Pharmacists practise the profession in different ways and in different environments. The front shops of some of these drugstores are totally different from others. Zellers sells tires and jeans, and the Woolco front shop sells furniture. Shoppers Drug Mart and Pharma Plus sell cosmetics and health and beauty aids. The Big V sells gift wares. The IDA sells greeting cards. The medical pharmacies almost exclusively sell over-the-counter products and prescriptions. Different strokes for different folks: We are all different from each other and we will be affected in different ways if this legislation goes through as proposed.

We urge you to consider the ramifications of your legislation, especially in the context of what the retail environment really looks like. Thank you, and we'll be happy to answer questions.

1430

**Mr McGuinty:** Thank you very much, gentlemen, for shedding some very important light on this debate. The visuals I found very helpful for us to gain a perspective of the physical location of the dispensary and its size relative to the rest of the operation.

The argument that's made here time and time again is the symbolism, that when people think pharmacy they think health care, and that when they think health care they will see it as something contradictory to that for pharmacists to be selling tobacco products. I have a great deal of difficulty believing that people see Zellers as health care, or Woolco or Loblaw's or whoever else when it comes to non-traditional pharmacists.

As I've said here a number of times, I have some difficulty even seeing the larger drugstores as purely providers of health care. Often I think of them as the place where you go because you get a number of other items, whether it's chips or shampoo or soap or deodorant or razor blades, which I believe aren't properly categorized as health care. I think you're both providers of health care and you're retailers.

My question will be for you, Francis. As I understand it, in the non-traditional pharmacies your dispensing fees are very competitive.

**Mr Mokenela:** That is correct.

**Mr McGuinty:** So you're not making a lot of money in the dispensing.

**Mr Mokenela:** We do.

**Mr McGuinty:** You make some money.

**Mr Mokenela:** Depending on the pharmacy.

**Mr McGuinty:** Right. How many people work in your particular pharmacy?

**Mr Mokenela:** There's one full-time pharmacist, three part-time pharmacists and two part-time pharmacy assistants or technicians.

**Mr McGuinty:** Can those people be re-employed elsewhere inside the A&P?

**Mr Mokenela:** Given the economic climate as I see it, it is possible but they will have a hard time getting jobs elsewhere if the pharmacy closes.

**Mr McGuinty:** Did they receive special training?

**Mr Mokenela:** Yes, there is training for pharmacy assistants.

**Mrs Cunningham:** This is probably one of the more contentious issues. I think you said it very well, and the government is also aware, that there's no proof that if we disallow drugstores to sell tobacco, this would reduce consumption. The reason we're here is the very purpose of the bill. It says in the notes, "The bill is intended to prevent the provision of tobacco to young persons and to regulate its sale and use by others."

We had a couple of compelling presentations this morning. Once was from the Windsor-Essex County Health Unit. They went so far as to say that if people are going to sell tobacco, anybody, they really ought to be licensed to do so. They need some clout. They need some responsibility. That's on the side of the person who's doing the sales.

On the other end, I think they agreed with our position here, and that is that we think young people should accept responsibility, that if it's illegal, it's illegal and there ought to be some way of enforcing it, some fine, whatever. We're aware that this does happen, at least in some other jurisdictions. I'm wondering if that would solve the problem of who sells it if (1) we license it and (2) we make it illegal to purchase it if you are under the age of 19. Those are pretty tough statements, but what's your response?

**Mr Steinberg:** I think that's really an excellent idea. Tobacco sales in drugstores are declining on their own. This is going to happen through your legislation. We're in full agreement with the legislation, other than taking it out of pharmacies. I realize the point that's been made, that we're a long way away from the front where we sell tobacco, but you have no idea how many people stop in the back of the pharmacy and ask us: "Is there anything you give me that will help me stop smoking? I don't really want to go to my doctor." We have the Nicorette chewing gum that we can sell over the counter.

The whole thing about these anti-smoking programs is that you don't just sell the product, send the person on his way and say he's going to quit smoking, because it doesn't work that easily. They have to have backup and information and support. When they come back to the



store for their second box, you ask them how they're doing, how it's going, "Is it really working for you?" and if it's not, we can maybe tell them ways they can improve their ability to quit smoking. If the gum is not sufficient, then we can refer them to their physician. Now we're using the patch and the patch is very successful in helping people to stop smoking.

That's what we're there for. We're the easiest, accessible health care provider there is in the province. Everybody has said that, and I guess we are. Being there 15 hours a day in my store, I certainly know we do nothing but answer questions half the day.

**Mr Winninger:** Sid, I realize you are in a bit of a difficult spot because I know that the owner-operators of Shoppers Drug Mart, controlled by Imasco which also has tobacco interests, are in a very delicate position. I spoke to one of your colleagues recently and she said she'd love to speak out against the sale of tobacco from pharmacies, but because she's a Shoppers Drug Mart owner-operator, that just wouldn't be possible. Yet so many of your colleagues in the business feel that their right to do business and sell tobacco products should never supersede this initiative towards a tobacco-free society.

I still have some difficulty with your position, particularly when I hear from many independent pharmacists who say it's downright embarrassing to have pharmacists come out in public and say it's okay to continue selling tobacco products from the same premises. How do you deal with this conflict?

**Mr Steinberg:** I'm really glad you asked that question because we get asked it several times. First of all, as a Shoppers Drug Mart franchise owner I want to make you aware, if you are not aware, that it is my choice to sell tobacco. It is not a part of my franchise agreement that I carry tobacco. I choose to carry tobacco because I'm in a very competitive environment in the mall I'm situated in. That's the reason, and as long as it's a legal product, I'll continue to sell it.

If it's as bad as it is, with all the medical evidence, why don't you ban it? If it's a poisonous substance and it's causing cancer, ban it. Get rid of it. Make the problem simple. Don't ask me to stop selling something that's legal when they can get it at 20,000 other outlets in the province, if you're going to close down 2,300 pharmacies from selling tobacco. That's not going to solve anything.

**Mr Winninger:** It's interesting because we've heard from pharmacists, including one from Coulter's drugstore today, a very old and established drugstore in London, indicating that when they gave up selling tobacco products in 1989 it had no effect on their profit margin. In fact, in the words of the young Coulter, it may have enhanced their profitability starting in that year.

The evidence seems to be that it's not going to detract from your profit margin. It's certainly going to inspire goodwill in the mind of the public that here's a druggist who's taking a strong moral and ethical stand in opposing the sale of tobacco products from pharmacies, and in the end help ensure that our young people don't have yet another avenue, through a health dispensary, to consume the product. What do you say to that?

**Mr Steinberg:** I'd like to respond to that very much. First of all, nobody said what the tobacco volume was in that store before he took tobacco out. I venture to say that it was nowhere near the volume of tobacco that these multimerchandisers, or even my store, would sell in a year. There is a big difference in profitability to a small store and to a store like ours or the mass merchandisers.

Second of all, he intimated that tobacco was purchased in several pharmacies; I believe they found it was being purchased in pharmacies, against the law.

1440

I don't know whether you're aware or not, but we have a very serious training program with all our new staff, everybody on staff at the time and any new staff. We have a 20-minute video that goes all through the background of where tobacco came into pharmacy—it started years and years ago—the problems it causes, the new legislation, and that we are not allowed to sell to anyone under 18 years of age and that if they don't have proof of age, then they don't get it.

**Mr Winninger:** The problem—

**The Chair:** I'm sorry, Mr Winninger.

**Mr Winninger:** May I just complete the phrase?

**The Chair:** I'm afraid we have gone over. I try to allow everyone to ask a question. I'm sorry that we keep getting caught by time.

**Mr Winninger:** I was just going to say a statistic between the dispensing pharmacist and the tobacco—

**The Chair:** Thank you for coming before the committee. I believe you're going to leave a copy of the submission.

**Mr Steinberg:** Yes, we've already given Mr Arnott a copy. Would you like these left at all?

**The Chair:** Yes, if you could perhaps leave them and we'll make sure you get them back.

LUNG ASSOCIATION, LONDON AND MIDDLESEX

**The Chair:** I then invite the representatives from the Lung Association, London and Middlesex. Welcome to the committee. Please make yourselves comfortable. We have a copy of your written submission. Please go ahead.

**Mr Bill Murphy:** Thank you. It's a privilege to be here. My name is Bill Murphy. I'm the volunteer president of the London chapter of the Lung Association. Brent Keeling is our honorary Christmas Seal chairperson, and Jim Belton is the executive director of our local association.

I'm here as a volunteer. I'm a partner in a national CA firm, and as a volunteer with the Lung Association serve as the volunteer president here locally and also as a member of the governing council of the provincial body.

The Lung Association represents the oldest health charity in the country. We're dedicated to the improvement of respiratory health both through research and through a variety of community programs aimed at the various generations of people suffering from lung disease.

The reason we're here, first, is to lend our full support to the legislation. We view it as one more step, but an important step, towards the ultimate elimination of tobacco products from our society. We're here, second,



to make certain recommendations regarding both the legislation and where we see this strategy that the legislation is part of—where it should go in the future.

Finally, I would like to have an opportunity for our chairperson, Brent Keeling, to comment on the effects of secondhand smoke on his asthma condition.

The recommendations we would like to make are, first, just to confirm that the committee understands that non-smoking should be recognized as the norm, that over 64% of Canadians 15 years of age and over are non-smokers; second, to recognize that the choice made by smokers to smoke is not a choice simply for themselves but is a choice for everybody, that when someone else smokes, everyone within their vicinity smokes as well. The only distinction is between mainstream smoke which is being directly inhaled and then exhaled from the smoker's lungs and the side-stream smoke that is inhaled by all others in the vicinity, which represents both the exhaled smoke coming from that smoker plus the two thirds of the smoke that is simply being burned off the end of the cigarette and never inhaled by the smoker in the first place.

We feel that in the long term all smoking in public places must be eliminated. We recognize certain practical choices that have been made in the current legislation in terms of how far one goes at this point to make sure this step can be put in place, but we feel it's important that in the very foreseeable future smoking in all public places and, equally importantly, smoking in the workplace, be eliminated.

If smoking is to be allowed in the workplace, there is a need for tighter regulations on ventilation. Scientists recommend that the ventilation systems should be capable of changing the air at least six times per hour, and there are very few of our buildings in this province that are capable of that right now.

Tobacco smoke is very attracted to the human body. If you get into the scientific of it, there's an electrical charge caused by smoke that is attracted to the water-filled human body, and therefore if it's absorbed into the walls and furniture of a building, even though the smoking may have taken place at some very earlier time, it still will be drawn out and attracted into the air that the people in that building are breathing.

We believe, as a contemporary issue in terms of the developments of last week, that the Ontario government needs to continue to stand firm on tobacco tax rollbacks. I believe personally, and I've written to the Prime Minister and his other ministers yesterday, that it is not acceptable that the health of our children be compromised by commercial interests and by political interests, and that it is not acceptable that tobacco taxes be rolled back as a politically convenient way to deal with many other interests.

The export tax I think, as you're aware, is a very simple solution to the current smuggling problem: You take the profit out of smuggling, you take away the issue. I believe that is the solution that should be put in place.

Finally, and again we recognize that Bill 119 goes partway in this direction, is to continue to increase the

health warnings that need to be placed on tobacco products to not only deal with the direct risks to smokers, but also to deal with the indirect side-stream risks to non-smokers as well.

We're here to lend support to the legislation. We are doing a number of things to assist, as a health-based organization. We have programs that are aimed at the current generation of smokers, particularly our countdown program to help them stop smoking. We are here to help the past generation of smokers who suffer from chronic obstructive lung disease, both with their health problems and also to deal with social issues that have resulted from their restricted ability to move about without oxygen supplies etc.

We're definitely here to help the next generation, because that's where the issue lies. It's stopping the next generation of smokers from ever starting to smoke. We run a "Lungs are for Life" program throughout the province that goes into the junior grades of our elementary schools, to teach them the benefits of a smoke-free lifestyle. In the London-Middlesex area, we see over 30,000 children per year with that "Lungs are for Life" program.

We also deal with the asthmatics, both the more mature and the younger populations, helping them learn how to deal with their conditions, how to avoid the triggers that cause asthma attacks, and secondhand smoke is a very important trigger. At this, point I would like to call on Brent to give his thoughts on that matter.

**Mr Brent Keeling:** My name is Brent Keeling and I am nine years old. I've had asthma since I was a baby.

Having asthma means that some things trigger a reaction in my lungs that makes it very difficult to breathe. I have learned to take medication and avoid the things that trigger my asthma. When I control my asthma, I can run cross-country, swim and play baseball. Cigarette smoke triggers my asthma and gives me a lot of trouble. Sometimes it's something I can't always avoid.

When I have an asthma attack, I just can't breathe. An asthma attack can be scary. I often can't talk and tell someone I need help. An attack can wake me up at night and keep me home from school. Other times, I just cough all night and go to school tired. Sometimes I have to go to the hospital. When I am having asthma trouble, I can't always do the things I like to do. An attack is not fun.

Many things cause my attacks, but one of the worst triggers for it is cigarette smoke. When others choose to smoke where I have to breathe, it is very difficult for me. I like to go to restaurants, ballparks, hockey arenas and places like that, but often my whole family has to move or leave an area because of other people smoking. Smoke sometimes forgets to stay in the smoking section.

Every time someone lights up a cigarette, I have to worry about having asthma attacks. Sometimes I can't always move away and that gets me angry. I would really like it if I didn't have to worry about that, because when you can't breathe, nothing else matters.

1450

**Mr James Belton:** I'd also like to congratulate the government for introducing the bill and the two opposi-

tion parties for supporting the bill. It's a good bill, but we would like to see it strengthened, particularly in the area of environmental tobacco smoke.

We'd also like to congratulate both the Honourable Ruth Grier and the Honourable Floyd Laughren for their stance against the federal government's proposed tobacco tax reductions. We're also delighted with the Premier's call last Friday for the federal government to introduce the export tax on tobacco.

Smuggling is an issue that should never be so-called corrected to the detriment of the country's health care policies. In other words, a tax reduction will only magnify the problem, not correct it. If the Canadian and Quebec governments proceed on this disastrous course, I'm afraid the Ontario government is going to get sucked in on it. This committee should then revisit this bill in the area of licensing. In licensing vendors of tobacco products, if that kind of thing happens with the Quebec and Canadian governments, then I think you'll have to take a look at licensing measures.

I mentioned that we'd like to see all public areas in the workplace smoke-free. The term "non-smoker" is a misnomer. When others smoke, you also smoke. Environmental tobacco smoke is the most serious contaminant to which non-smokers are ever exposed. Environmental tobacco smoke can be totally eliminated from the indoor air only by removing the source, and that is the tobacco smoke.

An estimated 500 Canadian deaths annually are the result of exposure to secondhand smoke. If 500 people died through a disaster that could have been prevented, we would do something immediately to rectify the situation. We urge the committee to remember that these are preventable deaths and that you now have the opportunity to prevent these deaths from happening in the future. We ask you to do so.

In closing, may I say that the Lung Association, London and Middlesex, supports the bill but strongly urges the committee to strengthen the bill in the area of environmental tobacco smoke. We strongly agree with the government's slogan, "Smoking: It will suck the life right out of you." Let us work together to preserve life by eliminating the number one preventable cause of death. The health of our children must never be compromised by commercial interests.

**Mrs Cunningham:** Thank you very much. That was very good, it Brent. I've seen Brent before in London, but I've never heard you speak so well. Congratulations.

**Mr Keeling:** Thank you.

**Mrs Cunningham:** With regard to your comments with regard to protecting people from secondhand smoke and all the concerns that you have at the Lung Association, is there any particular part of this bill that we should be looking at? Should we be expanding it to all public places? Is this what you're saying? What specifically do you want us to do?

**Mr Bill Murphy:** In an ideal world, our answer would be yes. We would say you should tick section 9, where the controls related to smoking tobacco are listed, and continue at point 9, where it says "a prescribed

place." We would continue to say that all public places and all workplaces would be added to that list.

**Mrs Cunningham:** You'll remember, during the workplace legislation, we took the stand that that bill didn't have any teeth, the 25% part and non-ventilation and the whole thing. You'll remember making your own presentation. That's a separate piece of legislation. Should we be looking at that along with this legislation? Should this committee be looking at both?

**Mr Belton:** It would appear to me that needs to be done. You're absolutely right that the bill did not give us everything we had hoped it would have. It's a hard piece to legislate. It's a hard piece to enforce. As somebody mentioned earlier today, 25% can be smoke-free. You can have four desks in a room, face to face, and have one person smoking and the other three not. That doesn't make a whole lot of sense to me.

It's unfortunate that the Labour department wasn't able to get together with the Health department to try to do that, but somebody's got to do it, and why not here.

**Mrs Cunningham:** There are two controversial issues with regard to people's responsibilities. The responsibility of the vendor has been raised today and the responsibility of the purchaser. The vendor, we have stated, the person who sells—we're obviously in favour of the legislation, but we think there's a problem in this regard; we think it should be toughened up—perhaps should have to have a licence. This should be an illegal product in our view.

Secondly, there's the responsibility on young people. I think there are far too many people saying: "They're victims and therefore it's all the vendor's responsibility. We need more legislation." Perhaps they should be fined if they, on purpose, go and purchase cigarettes in a drugstore or anywhere else, if they're under the age of 19. Your view on that: Would you be tough enough to say "Yes, maybe we have to licence vendors," and "Yes, maybe we have to make it illegal and put a fine on the individual who breaks the law by purchasing it underage?"

**Mr Bill Murphy:** I would put it in the context that, as I mentioned before, this bill is just one step in a strategy to remove tobacco products entirely from our society. The further down that road we can go at this point in time the better. Obviously, to fully achieve the removal of tobacco products from our society, we are going to have to introduce steps such as you set forth, Dianne.

**Mr Sutherland:** Thanks for your presentation. You mentioned tobacco taxes and the impact that would have on young people. Some have suggested that if we're bringing in this piece of legislation, which has the ability for inspectors and enforcement and is going to be effective, then why are people so concerned about reduction in tobacco taxes having an impact on young people? If you're making it illegal for them to purchase, what difference does it make what the price is?

The other comment that's been made to me that I'd like you to comment on is that if a significant portion of tobacco sales is illegal, how do you stop young people from purchasing? The question is, if you're getting into



the legal market, to the retailers, then you can enforce it there, but you can't do that in an illegal market. How would you respond to those two issues?

**Mr Bill Murphy:** The access issue has to be dealt with in two areas. The first is the physical access, which this bill is aiming to deal with; the second is the financial access. It's simply that the higher the taxes, the higher the cost, the less attractive it will be to minors to acquire tobacco either by somehow being able to get a legal establishment to sell it to them, or to acquire it on the black market, perhaps by their neighbour who's 20 years old going and buying a pack for them. I believe that the financial access is an important issue as well, and that's where the taxes come in.

Number two, although dealing with access to tobacco for minors is one part of the problem, the other issue is access of tobacco to all Canadians. Although we recognize that the most important step will be to stop the next generation of Canadians from smoking, we also wish to reduce the amount of smoking done by existing smokers as much as possible, and we see that the tobacco taxes will assist in that regard.

**The Chair:** I regret we're out of time, but may I, on behalf of the committee, thank all of you for coming here today. We appreciate it.

1500

JEFF ROBB

**The Chair:** Could I call on Mr Jeff Robb to come forward, please. Mr Robb, welcome to the committee. Once you're settled, please go ahead with your presentation. We do not have a copy of this presentation.

**Mr Jeff Robb:** No. I'll just talk to you endlessly here for a while.

**The Chair:** If endlessly can fit into 15 minutes, we'd appreciate it.

**Mr Robb:** I woke up this morning with a cold and I'm sorry it's taxing my voice a little. If I knew a good pharmacist, I'm sure I'd be able to take care of this.

Let me introduce myself. My name is Jeff Robb. I'm the owner of Turner Drug Store Ltd. Turner Drug Store has been at the corner of Grand Avenue and Carfrae in Old South London since 1948.

**The Chair:** I have to ask you, do you not know a good pharmacist?

**Mr Robb:** It is one of my problems.

I was a student at the University of Toronto and graduated with a BSc in pharmacy in 1983. I began interning in December 1983 towards getting my licence, and I worked at Turner Drug Store at that time. I was licensed in March 1984 and worked from then until the end of August 1987 for my father, who was then the current owner. He passed away in August 1987. I purchased the company from his estate in May 1988.

In the spring of 1988, I renovated the inside of my store and basically renovated tobacco out. I was tired of the tobacco in the store. Many people asked me why I went tobacco-free, why I did it. It was a personal decision. First and foremost, my father, Glen, died of lung cancer. That was a big impetus to get it out the door. I

don't think that was the biggest reason, though. To me it was ethics. It was just pure and simple ethics. It was my professional responsibility as I saw it.

I was tired of what I like to call the whiff-and-puff syndrome, to borrow another tobacco retailer's name, where they need a whiff but they have to take a puff of their controlled-dose metered inhalant in order to enjoy it. It's just bizarre. I have several individuals to this day who still rely on that method in order to get their nicotine.

I found it equally as hard to recommend or advocate cessation of smoking or smoking aids when the last thing that an individual saw when they left my store was the tobacco behind the cash register. It didn't sit well with me and I couldn't countenance it, so I threw it out. I sought no publicity or fanfare and I'm sure to this day that only the residents of Old South and my clients are the ones who know I've done it, and maybe they're the healthier for it. It's hard to say.

I have great empathy and sympathy for people addicted to tobacco as well as any other substances. I have great respect for those who choose to try to quit. I have even more respect for those who choose to try to quit, fail and retry and retry and retry, however many times it takes in order to quit. I have immense respect for those individuals. I do not, however, have respect for drugstores that are involved in the sale of tobacco, especially those citing economic reasons as the principal reason for not voluntarily going ahead with being tobacco-free. Everyone knows who they are.

Just to give you a little insight in terms of my own situation, in 1987, the year prior to my removal of tobacco, my sales were roughly \$90,000. I don't have any firm numbers on how much of that was represented by tobacco, but it seems to me it was in the \$60,000 to \$70,000 range, or roughly 78%. I figure the tobacco inventory at any one time was about \$3,500. In 1988, my sales rose to \$1.1 million, my inventory costs went down and my profits went up. In short, no financial ruin, no reduction of staff. In fact, the only number that did slide, interestingly, was the number of break-ins that were perpetrated against my business. In 1987 through 1988 I had five break-ins and since then I've had two. I think that number speaks for itself.

The reaction to going tobacco-free was admittedly mixed. I was equally vilified and lauded. I was a scoundrel and a hero. Some people vowed never to come back. I assume they didn't. I was constantly asked, "What is a pharmacy without tobacco?" and my answer was always, "A true health care facility, pure and simple." I was given congratulations as well, mostly by non-smokers, surprisingly. It was interesting. I had a very good staff to deal with the individuals who came up with questions and they fielded the questions in a professional manner. I give them top marks for that. They did a tiptop job.

I'm sure the variety store owners in the neighbourhood also thought they'd died and gone to heaven with the extra business that was spewing over to them in many ways.

Basically, why am I here today? Obviously, I'm not a public speaker nor do I really enjoy talking to a crowd.



I'm pleased to be allowed to speak and to thank the committee for coming to London. I don't think I could have gone to you, but it's certainly nice to have you come to me.

I want to congratulate the Rae government for several things: first, for the courage to be proactive regarding tobacco in general, but more precisely with regard to eliminating it from pharmacy sales. I'd also like to thank them for adopting the OCP guidelines as at least a framework for the change regarding getting rid of tobacco from pharmacies. I'd also like to congratulate them for having the courage to stand up in the face of the tobacco lobby, the Imasco lobby and all other lobbies that currently oppose Bill 119.

I'd also like to compliment my chief competitor, Big V Pharmacies. I never thought I'd actually do this, but I'd like to thank Norm Puhl for throwing the weight of his 100-plus stores behind the legislation. I feel that if Norm had acted maybe a year or two earlier, we wouldn't be sitting here talking about this. We'd have already had it out the door and maybe done on a voluntary basis.

I feel your government shouldn't have had to legislate us into doing something that I'm sure everyone recognizes should have been done a long time ago. I thank you for bringing our consciences together on this issue, even if some of my colleagues will only do so after a little kicking and screaming.

I know that my competition will comply with the legislation, and then they'll try to profit from it, put a good spin doctor to work and come out the heroes on the issue. I'm not looking for that publicity. All I want to do is express to you why and how I did it.

I guess the bottom line of what I'm trying to say to you is that stores will survive without tobacco. I'm living proof of that. Imasco and all the others have marketing departments and I'm sure they'll put them to work to help them compensate for lost revenue. I was my own marketing department and I did it. I'm sure that some suits can do the same thing for them, and they will. I appreciate your time.

**Mr McGuinty:** Thank you very much, Mr Robb. I think the first thing I want to do, and I'm sure you're prepared to acknowledge this, is to make sure that people understand, the people who are present here today and the rest of us of course, that there are a number of drugstores in the province which do not have tobacco backers. Pharma Plus, for instance, 133 stores, and I believe those non-traditional stores like Zellers, K mart and Loblaws, don't have any tobacco connections either. There's a substantial number. I know there's been an effort on the part of some to categorize all objections as being purely out of the self-interest of the tobacco industry, but I think it's important to get that on the record.

We've tried to get some numbers from the government, but it hasn't given us any with respect to potential job losses. We've had some presenters come before us and some studies have been done and the number's been as high as I guess 2,700. Are you maintaining there would be no job losses?

**Mr Robb:** I can't speak for the industry. All I can speak for is my own particular experience, and my particular experience was that the community rallied around it and thought it was a good idea. I saw new faces. My profits rose, my sales rose and no one was let go.

**Mr McGuinty:** I want to speak to you I guess on an intuitive basis. You tell me whether you agree with this. If we tell an industry or a retailer, it doesn't matter who they are or what they're selling, "You're going to have to drop your sales by 7% or 8%," it seems to me that's going to have some kind of a negative impact. Wouldn't you agree?

**Mr Robb:** In a way. It's a circle, though. The equation doesn't stop there. What do you do? If you lose the inventory, you simply move that inventory into another space at the store or do something with it in order to compensate. I think most of the chain drugstores have marketing departments. That's what they're there for. They're going to find a way to compensate for the revenue loss. Like I said, I'm one average Joe and I did it. Chances are that with the money they have and the resources they have, they'll put it to good use.

**Mr McGuinty:** Just one final question: Should the government be providing some kind of a guarantee to all employees of pharmacies across the province that there will be no jobs lost?

**Mr Robb:** I hope you don't try that line on anybody.

**Mr McGuinty:** I just did.

**Mr Robb:** I don't think it's possible. I don't think you could say that.

**Mr McGuinty:** I think there would be some jobs lost.

**Mr Robb:** Perhaps.

1510

**Mr Jim Wilson:** Thank you very much, sir, for your comments. I want to comment on behalf of Big V, because they're often cited as leaders in this field. Apparently Norm Puhl's position is he doesn't agree with the ban on the sale of tobacco products in pharmacies. In fact, Big V's position is you shouldn't just pick on one retail sector or part of a retail sector, that it should go into licensed establishments like the LCBO or the beer stores, that there should be a tobacco control board.

Garfield Mahood of the Non-Smokers' Rights Association agreed in his presentation. In fact, he told Big V a year before it made the ban that it would be a smart marketing move and good positioning in the market if they were to get out and get the publicity for what apparently Garfield Mahood knew was an inevitable thing the government was going to do. He must have the inside track with the NDP because he knew it was—

**Mrs Haslam:** It's news to him.

**Mr Jim Wilson:** He told Big V, "It'll be inevitable; it's going to happen anyway under this government, so you might as well lead the pack." I was able to verify this when he appeared before the committee. I just wanted to bring that forward. That has been the position of my party, exactly what Big V's position has been, and that is that you can't just, on a strictly business side of

things, pick on one retailer or the other.

I've also done, I've discovered, the largest survey of pharmacists in the province, because I've been waiting for a week now for somebody to come forward with a larger response rate than the one I did. I mailed to all 8,000 pharmacists in the province, and I only got 570 replies, but I've discovered from both sides of the—

**Mr Robb:** You represent the PCs, is that correct?

**Mr Jim Wilson:** Yes. I thought it was a dismal response rate, to tell you the truth, but other people get 60 when they mail to all 8,000 pharmacists in the province.

Of the 570, 77% of those pharmacists said the NDP government should not be able to ban the sale of tobacco in their stores. Included in that 570 were 112 pharmacists who had already voluntarily taken tobacco out of their stores but they agreed, on a business principle, that even though they'd voluntarily done it, the government shouldn't be forcing the rest of them.

I just simply put all that on the record to clarify a few of the points that you made and welcome any further comments you might have.

**Mr Robb:** I like the legislation the way it's written, if only for the fact of getting it out of pharmacies. It's not necessary in the pharmacy. You can get it elsewhere. If you choose to smoke, that's your business. I don't want to be selling anybody a pack of smokes. It's silly, stupid, ridiculous. That's my position.

**Mr Winninger:** It's certainly a pleasure to have you here today, Mr Robb, as a former consumer of Turner's when I lived on Grand Avenue back in the late 1970s. I certainly appreciate your transition to a tobacco-free pharmacy.

I think you were present for an earlier exchange I had with another pharmacist-owner at a time when I severely challenged the Chair's patience, but this comes back actually to the question I was going to pose to Mr Steinberg at the time. It seemed to be his approach that voluntary compliance was the way to go. Clearly, with 13,000 people dying every year of smoking-related diseases, we can't move too soon on this, but it seemed to be his approach that it was appropriate for pharmacists to stock tobacco products in their stores because they could give warnings to people against abusing the product.

I'm wondering whether you would agree with me that, in practice, the pharmacist isn't going to be able to closely monitor what goes on at the tobacco display counter, which might be at the front of the store while the dispensary is at the back, and furthermore that if a pharmacist like you takes clear and progressive action to remove the tobacco products, it's going to signal to your consumers that tobacco consumption is a very bad habit to continue with and that you might convince one customer or more to refrain from tobacco use by doing what you've done.

**Mr Robb:** Where the tobacco used to be in my store is now populated by smoking-cessation aids or literature thereof.

**Mr Winninger:** Is there a takeup on those products?

Are people buying, or are these gratuitous?

**Mr Robb:** It arouses their interest. Smoking cessation is directly proportional to your own will and how much effort you want to put into it, and when the time is right, the time is right. As I said, many people try once and fail; try again and fail; try again; try again. Sooner or later, they either want to do it or they don't, and those are the people whom you should give the support to. But don't do it with tobacco in the store.

**Mr Winninger:** When people come in and ask for cigarettes at your store, what do you tell them?

**Mr Robb:** The pat answer is that we stopped selling cigarettes in 1988 for health reasons. We felt it was against our professional mandate to do so.

**Mr Winninger:** What kind of answer do they give?

**Mr Robb:** It varies. Some people say: "Well, what's a drug store without tobacco? I'm never coming back here. You're going to make me walk the extra block down to the variety store." Sometimes it's, "Gee, that's a good idea. Maybe I should quit."

**The Chair:** Mr Robb, thank you for coming before the committee this afternoon. We appreciate it.

#### WILLY'S COIN MACHINES

**Mr Willy Schmitthen:** My name is Willy Schmitthen and I'm from Chatham. We run a small vending business. This is my wife, June. She's my partner in everything.

We realize that the intent of Bill 119, in particular section 7, is to lessen health care costs by reducing the number of young people who become first-time smokers. We have no argument with this. However, in this most depressed time, this proposed anti-smoking legislation as it stands will in fact put many businesses out of business. Please reconsider this strong stance.

It has been our understanding that the NDP government was backing and encouraging small business. This is quite a turnaround. What has happened to the government's support of free enterprise? We are selling a legal product.

Please consider a compromise which would work towards your goal yet keep small businesses operating, at least enough to pay operating expenses and our taxes. Allowing vending machines in licensed bars would hopefully keep our heads above water. We propose to move machines away from bar entrances, in full view of the bartender. In most instances, buyers have to purchase loonies from the bartender in order to use the machine.

Tobacco sales are down and smoking is already no longer socially acceptable in many places. Our own sales are down considerably from just one year ago. Every year we voluntarily take machines out of service in locations which are no longer profitable. Over the next five or six years, you will find that the number of cigarette machines will be greatly reduced. We feel this gradual reduction will give us time to diversify.

Statistics show that less than one percent of all sales in Canada are from vending machines, so the percentage of young people purchasing from vending machines must be close to nil. If you watch the high school crowd, you will realize they do not congregate during their lunch hour or



after school in local bars. They hang out at the corner variety store, at 7-Eleven or Becker's. Furthermore, they do not purchase cigarettes from vending machines because of the higher cost. They can obtain them much cheaper through older friends. You will gain nothing, and we lose everything.

I own a small vending business which is 90% cigarette machines. As you can see, my business will not be able to survive without the cigarette machines. We won't just lose our business, but will go into debt. Has compensation been a consideration? Since the machines will be obsolete, we will lose the value of our assets and we will go deeper in debt with the cost of removing the machines. Death by smoking is a long-term process. Don't kill our business overnight. Let's be fair to both sides of this controversy.

In closing, we propose that vending machines be allowed in licensed bars. Hotel operators are very supportive of this and are assisting in a petition. We also have the full support of our member of parliament, Randy Hope. Very little will be gained by removing the machines, and at the same time this would allow the small business person to stay in business. As it is, this summer we must remove machines that are not in licensed establishments to conform to the federal legislation. This will cut our sales considerably. If the machines are to be removed completely, we should at least get compensation for them.

1520

**Mrs Haslam:** We had a vending machine group come to us when we were in Toronto, and I asked them the percentage of their business which was tobacco machine related. I see that you have 90% cigarette machines. What other kinds of machines do you carry in your business?

**Mr Schmitthen:** We have some soft-drink machines and some candy machines. We have to diversify just to keep up with the times.

**Mrs Haslam:** One of the comments from the parliamentary assistant at the time was to put it in the context of the federal legislation in licensed premises, and in Ontario licensed premises do include family restaurants, where the machines are sometimes downstairs by the washroom or they are at the entranceway. It was one of the things we had to take into consideration in looking at this particular piece of legislation and where it went vis-à-vis the federal legislation.

One thing the group asked for that I think all of us were very interested in was an extension of the time lines. They said: "Even if we have to take all the vending machines out, at least extend the time lines beyond the three months. If you're going to give pharmacies a year to comply with legislation, at least give us the same amount of time. We already have to take out a majority of our machines because of the federal legislation coming in." They asked for an extension of time. Would you be in agreement with that particular case?

**Mr Schmitthen:** How long a time?

**Mrs Haslam:** I believe they mentioned the same amount of time as pharmacies, one year versus three months.

**Mr Schmitthen:** I believe there's a difference between a licensed establishment and a licensed bar. In a bar, you have to go to the bartender to get change, and most of them are adult bars. That's where you really sell the cigarettes anyhow. It's not profitable to have them in a restaurant. In a family restaurant, you might as well forget about it.

**Mrs Haslam:** Can I have one more quick question? That didn't answer my question, but I wanted to get one other item on.

When you say you don't sell to young people, this morning we had the Lambton county group come in and indicate in a questionnaire that they had through their high school that 78 out of 216 young people did and were able to buy cigarettes from vending machines. In their own questionnaire at a high school, we find that a certain percentage of young people do have access to the machines, and this is legislation that is very concerned with that access by young people to the purchasing of tobacco. So I would pass that on, and still my question was around the time lines.

**Mr Schmitthen:** I believe it should be just left alone. Eventually the machines are going to disappear anyhow, and from a small business point of view, it's hard to make a living the way it is right now anyhow. We don't want anything taken away. We've been in this business for about 20 years, so it's quite a blow to us.

**Mr Jim Wilson:** Sir, I realize that in the first part of your presentation you were probably trying to soften the government up by referring to them as somehow being pro-small-business, but I can tell you that in the three years they've been in, I can't think of one thing they've done for small business except drive a whole pile of them out of the province, including this legislation, it's been suggested by a number of pharmacists.

Michael Decter, the previous deputy minister, used to say in meetings, "One of the problems with our drug costs is there are just far too many pharmacists in the province." Anybody can become a pharmacist. We've had testimony here that as long as you meet a few different criteria under the various acts, you can set up and hire a pharmacist. Your store could be a pharmacy.

It's been suggested, we know from a Coopers and Lybrand study, that possibly 104, I think it is, pharmacies could go out of business, and that really this is the government's backdoor way of getting rid of a few pharmacies. That's one of the suggestions. Unfortunately, they brought the health lobby along with them in their way of doing this.

But there's no proof that by getting rid of the sale of tobacco products in pharmacies—I don't think it will in any way reduce consumption, because people will just go to other stores. I just wanted to say that.

Secondly, my party and I have a great deal of sympathy for your position, and we have, from the very beginning, said that the government should compensate people like yourselves. I don't think the government will budge. I said on second reading debate that while the federal government has moved it into licensed establishments, this government, in order to get a big bang out of



this exercise, wanted to go one step further than the federal government. So they're going to ban all vending machines.

I don't think it'll have much effect—less than 1% of tobacco sales are sold through vending machines—and I agree with your position that if it was in a supervised area, like near the bar, which is the legislation in a number of states in the United States, for example, that would be good enough. That was sort of the intent of the federal legislation.

Given the fact that we're going to try and keep pushing them on the compensation issue, and 90% of your business is cigarette vending machines, what kind of dollars are we dealing with here just for your business alone?

**Mr Schmitchen:** To change a machine just to take loonies costs about \$500. Then you still have the labour on top of that and the price of the machine. I would say about \$1,500 per machine.

**Mr Jim Wilson:** How many machines do you have?

**Mr Schmitchen:** We have 40.

**Mr McGuinty:** I think you've raised a very reasonable question, and that is, if the object of the exercise is to make it harder for kids to start smoking, why are we banning vending machines in licensed bars? Let's forget restaurants. Let's just talk bars. I don't know if the government has any numbers on how many kids are getting cigarettes from vending machines in bars but I haven't seen any.

Tell me just a bit about this system of loons. I gather it could be a further protective mechanism. If I'm sitting at a bar and I want to get cigarettes from the machine, how does it work? It doesn't take money.

**Mr Schmitchen:** It takes loonies.

**Mr McGuinty:** Oh, I see. I thought you were talking about a token system.

**Mr Schmitchen:** No, it's loonies. Everybody calls them loonies.

**The Chair:** That hasn't reached Ottawa yet.

**Mr Schmitchen:** Years ago, when I first started in this business, they used to have a stamp. You'd buy a licensed stamp for a machine. In that way, you were designated to that location only and they could keep track of where the machines were if they wanted to have some kind of control over that. That used to be years ago, and when we got switching governments that went out. That's how they used to keep track of things. It might be a suggestion.

**The Chair:** Thank you for coming from Chatham and making your presentation today. We appreciate it.

PST OFF ASH, PUFF OUT CAMPAIGN

**Dr Terry Polevoy:** Thank you for allowing myself and one of the associates in my organization to be here today. I am known throughout Ontario, and in fact the United States and Canada, as possibly the tobacco industry's worst nightmare. I annoy people. I cajole people. I'll be taking some of them to court in the next few months. I'm a soldier in the fight against tobacco.

Rick Bebenek is a grade 12 student at Preston. He's 18

years old. To kick our presentation off he's going to ask each of you to take a little selection from our grab bag. We're going to have some fun today. Rick, do you want to make sure everybody gets at least one piece? Some of you probably will not want to keep what we're going to hand you, but we'd like to have it back. They're mementos of my wars against tobacco.

**1530**

As a former paediatrician, and a soldier in the movement against international tobacco cartels, I salute you for your efforts. I founded PST OFF ASH, pronounced pissed off ash, in March 1993. It stands for People Stopping Tobacco Organizations Funding Fine Arts, Sports and Hospitals. We originally started with just the A for arts because we picketed the Guelph art centre fiasco last year.

We serve as advocates for people who are victims of second-hand smoke in the workplace and for children who are victims of their parents and caretakers. Our goal is to bring about zero tolerance for smoking in schools and the workplace. We are asking for people to bring their grievances to us because frankly, ladies and gentlemen, no one else gives a damn in this province.

Tobacco and smoking are major health problems, but are even larger social problems. You've heard evidence from many experts and I'll not repeat what they've already told you. I'll tell you a little bit about my personal experiences and then I'd like to open up the floor for discussion.

I'll go around the room, and just hold up what you've got. You'll be last, actually. Mr Wilson, what do you think that represents?

**Mr Jim Wilson:** I don't know; a child or a young person.

**Dr Polevoy:** Hope in the children, that in the future they'll be smoke-free. Mr McGuinty, did you pick up one of our little ditties over there?

Mrs O'Neill, what have you got?

**Mrs O'Neill:** A magazine.

**Dr Polevoy:** Okay, open it up to any page and try and find us an ad about health, and before the end of the show, I want you to report to us how many tobacco ads were in that magazine. If you see a tear-out page that means I've ripped them all out, so you may not find any.

Mr Eddy, can I ask you if we gave you something?

**Mr Eddy:** A "Preston High School Making a Difference" mug. I don't know what the emblem means.

**Dr Polevoy:** Can you tell us about the emblem, Rick?

**Mr Rick Bebenek:** It's just our school symbol.

**Mr Eddy:** Oh, I thought it was a bear paw.

**Mr Bebenek:** It's just a paw, our mark in school.

**Dr Polevoy:** Mr O'Connor.

**Mr O'Connor:** I've got a magazine with a young person and a cigarette in her hand.

**Dr Polevoy:** What's the lead article there, not about the band but the other lead article?

**Mr O'Connor:** "American Secret Police."

**Dr Polevoy:** Okay, another lead article.

**Mr O'Connor:** "Exiles on the Mainstream."

**Dr Polevoy:** Okay, keep going.

**Mr O'Connor:** "War Pigs: Clinton's Military Sleight of Hand." "AIDS Coverup: What the Government Doesn't Want You to Know about HIV."

**Dr Polevoy:** Did you know that smoking doubles your risk of developing AIDS? Anybody know that? It does. Mr Beer, do you have anything?

**The Chair:** I have some nuts.

**Dr Polevoy:** Okay. Who makes those nuts?

**The Chair:** It says "Eagle."

**Dr Polevoy:** Do you think they're a part of an evil empire of tobacco lords?

**The Chair:** I have no idea.

**Dr Polevoy:** I don't know either but Planters is. Mr Rizzo.

**Mr Tony Rizzo (Oakwood):** A magazine.

**Dr Polevoy:** Yes, what is on the cover?

**Mr Rizzo:** Some pills and cream.

**Dr Polevoy:** That's an article from the New York Times magazine about how to commit suicide. Karen Haslam, what have you got?

**Mrs Haslam:** Self magazine.

**Dr Polevoy:** Okay. I want you to count the number of tobacco ads in that magazine, unless I've ripped it to shreds, and find out if there are any Canadian brands in there, by name only.

Mr Sutherland, I'm glad you picked what you picked. Who doesn't have something? Do you want to hand that little box of stuff out? Mr Sutherland, you were very quiet. I taped 20 hours of your committee this week and you were one of the quietest people.

**Mr Sutherland:** I'm filling in today.

**Dr Polevoy:** Oh, he's filling in. Now can you please read the title of this little magazine here?

**Mr Sutherland:** Yes. It's called Our Children; the Parenting Magazine.

**Dr Polevoy:** Who prints that?

**Mr Sutherland:** It says, "Compliments of the Bay."

**Dr Polevoy:** Okay, now open up to the centrefold, please. Read the top of the page and just sort of flash it at everybody, please.

**Mr Sutherland:** Okay. It says, "These companies care about our children."

**Dr Polevoy:** Name five companies at random.

**Mr Sutherland:** United Transportation, Merrill Lynch, Spar, Chubb, Nutrite Fertilizers.

**Dr Polevoy:** Okay. Look at the second page, bottom left. What's there?

**Mr Sutherland:** Imasco.

**Dr Polevoy:** Imasco cares about children, right in black and from the Bay. I rest my case on advertising and the media influencing children. The only thing we don't have is Joe Camel, but in some of the handouts I gave you we've got lots of ads, we've got lots of goodies and we have the start of a game.

I'm going to be making a game based on this particular school trip that we go along. We start out at home plate where the kids can pick KKK cigarettes, which stands for Kills Kids Kwik, and their warning is this, "If you're stupid enough to smoke, the very worst."

Head towards first base and you look for your teachers to retire and let them pay their own OHIP fees because they, ladies and gentlemen, the teachers of this province, are the ones who allowed smoking in schools to begin with back in the 1960s and 1970s. They promoted smoking in their peers and their students as well.

In our area in Kitchener there isn't a single school that is smoke-free except Resurrection Catholic Secondary School and the school boards refuse to act today. We have asked for help from the Ontario Medical Association. We've asked help for Ontario Council of Administrators of Hospitals. We've hired an attorney. It's going to take us \$5,000 to start the lawsuit and probably \$25,000 before it's finished, and that's before it goes upstream towards Ottawa or towards wherever it's going to end up. Let me tell you the teachers are our worst enemies.

First base: "Mama Mia's Bingo. We serve from womb to tomb. Strike here." The bingo parlours have been striking in our communities since the inception of bingo. We have a school in our city, Resurrection high school, the only smoke-free high school between Toronto and London, that actually allows their students and promotes bingo in a smoking area.

We had a teacher at Cameron Heights Catholic School who smoked for 40 years and he told me about three months ago: "Terry, what's all this crap? What's all this hassle? I smoked for 40 years, it didn't hurt me and I quit by myself. What do I care if students smoke?" Why? Because one of my 14-year-old students works at the bingo parlour where they hold their events. She works in the kitchen. Some kitchen: potato chips, pop and maybe a peanut butter sandwich and she's in the room with the smokers.

**1540**

I went to the school board: no answers, very few questions. The chairman of the school board said in the paper the next day: "We can't do anything about public school smoking. It'll be too dangerous."

He used to work for the police department. He quit the police department after 11 years, went to work for the SIU; hasn't done a stick of work for these people for three years and is drawing a salary of between \$54,000 and \$58,000. Guess what, ladies and gentlemen, he's running for mayor this year. Dom Cardillo, the other apologist for tobacco in our town, is retiring. We are fed up to here with politicians and wannabe politicians.

Turn to second base. We want to boycott Wendy's, McDonald's, Burger King until they ban all smoking. George Cohon sent a very apologetic letter to me saying his air quality is five and a half times better than the average home, yet he owns a McDonald's in Moscow that has served 69 million, maybe 70 million customers since they opened a few years ago. I don't speak Russian. My grandmother did, but I never got a chance to ask him



whether they allow smoking in that restaurant.

Second base: called the Bitch 'n BIC. It's a small picture of a lighter, dangerous weapon in the hands of kids. It's a status symbol. They're in the colours of the cigarettes and for years they were put in people's Christmas stockings as if it was a fun thing to give in a Christmas stocking. It was outlawed in this country to have emblems that resembled cigarettes.

Second to third: We want to stop Becker's, Farrah's and Short Stop's from having cigarette counter displays. I walked into a Becker's near my house, surrounded by two elementary schools, two churches, next to Shoppers Drug Mart and a smoking doughnut shop in a middle-class area of Kitchener. My wife was terminally ill with cancer last year, so we sort of used that as a convenient place to stock up on items. Never went to the Shoppers; it smelled like chemicals. I was very chemically sensitive; I couldn't go in there. But the Becker's—nice people. Young kids worked there. You got your ice cream cones and everything and 27 million kinds of candy bars, including the Wunderbar.

One day I went in there during the cancer society fund-raiser or Easter Seals where they have little daffodils sitting on the counter, and I thought there was a sign sitting back there saying, "Put your coins in here and donate to the cancer society." Ladies and gentlemen, what was behind there were six packages of pouch tobacco surrounded by the daffodils with a price on them, and I just about puked. I wrote a letter to Becker's three times and called them six times and never got an answer. Since then, the store has changed hands and they've got bars on the windows, but kids still go there to buy their cigarettes, or to the parking lot at the school or the church.

Number three, here's another lighter. What's that look like? A Zippo to everybody? Arson 101—stylized one. This got triggered in my mind when a girl in high school aged 15 or 16, in London, set a mattress on fire while she was on her school break last winter. Anybody from London here? Do you remember that story? She killed, I think, a 38-year-old man in a rooming house. She went back to set the fire twice. It wasn't good enough that she started the mattress on fire once. These children are out of control.

There was a kid on the playground, Sunnyside elementary school in Kitchener. I go there to speak regularly. They have the best anti-smoking campaign in the world for those kids. Twenty-four kids a year go through the program. They're either kicked out of school or go through the program. I can play a tape for you about my participation. However, this is the school where a kid poured lighter fluid on a student. Anybody from the Kitchener-Waterloo area? We did have an NDP person, but he's independent now.

That kid wasn't even kicked out of school for more than a day, but the people in town were really pissed. They got very angry and asked that the child be thrown out of school or be given counselling. He was this far away from lighting this kid on fire. Why? Because lighters and matches are tolerated in grade 7. That's enough. I've had it. We want these kids expelled and staying at home if they're going to be smoking. I don't

care how old they are. It's a dangerous weapon.

The 4Rs for returning to school:

Refuse school-sponsored bingos. Call the school board. Call your minister. Call your doctor. You should not be made to go to a smoking hall.

Report stores that sell to minors. I invited a police chief to our meeting of our coalition that I'm no longer a member of, because they sit around and just hold hands with each other and collect government grants. I invited the police chief and who happens to be there? Three policemen show up in my absence. My wife went into a coma in November. It was the last meeting in October. They came up to me afterwards and asked me to resign from the coalition because I was too militant.

Rick and I and his friends were going to a sting over Christmas vacation after warning every storekeeper in town and taking a survey, just like they did, I think, in Brantford. They do in Colorado. They do in Illinois. You heard the stories. I was told to butt out and get out of everybody's way. Why?

Within a block of the police department in Waterloo there are at least half a dozen places you can go into and buy cigarettes by the piece or go into the bowling alley and put your money in a machine. There is no control. I resented very much my reputation being smeared by the police department and I had no recourse.

**The Chair:** Perhaps you could bring your presentation to a conclusion because we are over the 15 minutes.

**Dr Polevoy:** I have three separate preparations here that I will leave you, plus the list of other things. I'm sorry I took up all your time. I'm very angry, but I'm very focused. We're going to see this to an end and if it takes a lawsuit against a department of the government for inaction, it's going to be done. We want an Ombudsman to be on our side for a change. Thank you.

**The Chair:** We thank you for the submission and also for the material you've left with us.

**Dr Polevoy:** There will be a complete submission from me, all 25 or 30 pages, and 35 copies I'll leave with you before the 18th.

**The Chair:** Thank you very much.

HEART AND STROKE FOUNDATION OF ONTARIO,  
LONDON-MIDDLESEX CHAPTER

**Mr Brendan Murphy:** My name is Brendan Murphy and I'm the area coordinator for the London-Middlesex chapter of the Heart and Stroke Foundation. Thank you for allowing me to be here. I'd like to present our support for Bill 119.

The Heart and Stroke Foundation applauds the government of Ontario for honouring its commitment to the health of its people by introducing long-awaited legislation to reduce tobacco use.

As part of the Heart and Stroke Foundation, our mission is to reduce premature death and disability from heart disease and stroke by raising funds for research and education, and a major opponent to our cause is tobacco. In fact, tobacco is the single most important modifiable risk factor for heart disease and stroke and that is why we strongly endorse and are in favour of Bill 119.



Tobacco causes about 38,000 deaths in Canada a year, 13,000 in Ontario, of which 40% will be cardiovascular related, having a major effect on our goals to reduce premature death and disability. It's a major factor that we continually fight against each year.

We believe the best way to decrease these statistics is to take action to protect our youth. We believe that if youth are not smoking before the age of 20, we believe in the statistic that it will have less effect on them and that they will not be smokers in the future and as a result will live healthier lifestyles and be more productive Ontarians and Canadians.

Our objectives are to create a society where children are not enticed by cigarette ads and packaging, cannot readily access tobacco products and where they see society assigning appropriate measures to control the lethal product, which is tobacco.

Consequently, the foundation is pleased to strongly endorse raising the age of a minor to 19, establishing signage requirements to make retailers, their staff and the public aware of the law, and reducing tobacco sales outlets through the ban on sales in pharmacies and vending machines.

The government's commitment to removing tobacco from pharmacies and banning machines is an important step to decreasing access to tobacco products for Ontario youth and we feel it's an active step in saving lives, period.

The Heart and Stroke Foundation also recommends an effective system of licensing retailers that can be strictly enforced to reduce the sales to minors. While in principle we support statutory prohibition on sales to minors, it must be carefully monitored and a mechanism for reviewing its effectiveness and enforceability must be included for that to happen. If it doesn't happen, we feel that definitely licensing should be in place.

We recommend that the chief medical officer of health be charged with the responsibility to report annually on its effectiveness. If it proves to be ineffective and unenforceable, it is recommended that a retail licensing system be implemented.

As far as packaging is concerned, we believe in enforcing plain packaging regulations. Kids see packaging, whether it's their father with it, whether it's their teacher, whether it's a professional athlete. It's a direct endorsement. People respond to packaging. I don't think anybody can deny that. It's a major factor for any kind of consumer product.

As far as the environment is concerned, Bill 119 doesn't offer the workers of Ontario any further protection from tobacco's deadly effects. Consequently, we recommend that Bill 119 be strengthened to prohibit smoking in an indoor environment. We think people should petition, whether it's a bingo parlour or whatever, to have permission to be smoking. I don't think the government should be saying this, this or this, because it leaves the door open for a lot of people to stretch the law.

1550

We also believe that smoking, if it is permitted, should

be restricted to enclosed areas which are separately ventilated under negative pressure and exhausted to the outdoors. Overall, we believe this because we believe that ETS is responsible for more than 4,000 deaths a year.

Developing an effective tobacco strategy demands that we all get together on this—health agencies, governments, non-government organizations—to create partnerships and find the most comprehensive and also cost-effective way to take care of this problem and give people an easier way to make healthy choices for their future, especially the youth of today.

I don't think anybody here denies that tobacco kills. Even the person who had the vending machines basically said that it kills people. What more do you want? I've seen it personally. I've seen it in a lot of people and I've seen it now that I'm with the Heart and Stroke Foundation. I think we can overcome economic factors to make sure that we don't let people die. I don't think it's something that we say: "Okay, they're going to die off later. Let me earn some revenue now." Everybody is restricted in businesses today. Whether you're a landlord or whatever, there are restrictions on how you can do business. I think we have to enforce these.

We urge the government of Ontario to complete its important work initiated in Bill 119 and pass it without any further delay. I thank you for the opportunity to be speaking here today.

**Mr Jim Wilson:** Thank you for your presentation. I want to look at packaging, on page 7, because I know the Heart and Stroke Foundation of Ontario and various other groups consistently mention this in their brief. I guess my question is to the parliamentary assistant, really, but for the benefit of all. With respect to kiddie packs, maybe you could just clarify. I don't think the legislation specifically talks of banning kiddie packs, but I believe it's the government's intention and that's why you have the regulatory powers there. Do you want to expand on that? It keeps coming up. Maybe it's one thing we could eliminate from these hearings if the government would just tell us what its intention is with respect to packaging.

**Mr O'Connor:** With respect to my colleague and the question around the legislation around packaging, some of it has the ability to be done through the regulations which are yet to be tabled. If there are suggested amendments that you'd like to make, we'd be willing to look at them as well so that we can clarify perhaps some of the intention here.

**Mr Jim Wilson:** I certainly don't have any problem with anything you've mentioned under the packaging section. I would ask the government, though, what is the government's position with respect to generic or plain packaging? If you're asking for regulatory power, I assume you know what you're going to do with it.

**Mr O'Connor:** Part of the difficulty we've had, as stated before by the minister, I believe, was that the packaging most often falls under federal legislation. We're hoping that the federal government will move in that area. We do have some regulating ability there and I look forward to an amendment, perhaps from yourself, in that area.

**Mr Jim Wilson:** In other words, you're just palming it off to the opposition parties.

**Mr O'Connor:** No. The fact of the matter is that it falls under—let me say it a little slower for you—federal legislation.

**Mr Winninger:** We want the Tories to do something.

**Mr Jim Wilson:** We've been running the agenda at Queen's Park for—

**Mrs Cunningham:** We have to run it in opposition. That's what's so frustrating.

**Mr Jim Wilson:** We're trying to get you straightened out. Now you want us to straighten this out for you too?

**The Chair:** Order.

**Mr Jim Wilson:** I just thought I'd call your bluff.

**The Chair:** The committee has been very good today, but ladies and gentlemen, perhaps we could focus on the representative from the Heart and Stroke Foundation.

**Mr Jim Wilson:** A very useful answer. Thank you.

**Mr Tony Martin (Sault Ste Marie):** It was certainly good to hear your presentation today. It seems to me, from having sat through a week and some of hearings, that we get folks coming forward who present the health side of this question, and then we get others who sometimes are connected to the health profession who talk to us about the retailing side of this.

I had a very interesting conversation over the weekend with a group of community college student council presidents. The issue that came up there and sometimes comes up in the tradeoff between the concern about health and the concern about freedom to retail and do business is always one that's quite interesting. The student council presidents were concerned that we were laying something on them that was going to get in their way in their student life centres; you know, running the pubs and allowing people to smoke and the revenue that's generated there.

They had some concern that we were going to do that, and certainly there have been people here today, particularly from the chain drugstores and those kinds of places, who have a concern that we're stepping over the line into an area that we really shouldn't. It's always under the guise of freedom. Perhaps you could help me understand that a bit.

**Mr Brendan Murphy:** Sure. I consider myself very much an entrepreneur. There comes a time, and we've all decided; we all realize the effect of this product and that it kills people. There are restrictions on everything. We're trying to somehow get a product which we've said is legal for a long time—I think we all agree that we shouldn't have it—and we're trying to find the best way to get rid of it. We're just making excuses by saying that it's somebody's right to sell a product that actually kills people.

Is it a drug dealer's right to sell drugs? He's got a right to earn a living, but it's a drug and it kills people. If you're a landlord, even supply and demand dictates that your property is worth a certain amount of money, yet you can't charge that amount of money. Why can't he do that? Why don't we have free trade yet? Things are

put in place for certain reasons, to protect the majority of Canadians, and I think that's the same with the sale of tobacco.

**Mr Martin:** In your mind, then, there is absolutely no rationalizing this one. It's clear that this is a product that kills people and so we shouldn't be doing it in any form or fashion anywhere.

**Mr Brendan Murphy:** Ideally, that's what I believe. I believe that in an economy there's a good way to go about doing this. I think that for a pharmacy to sell tobacco is just unethical. At the Heart and Stroke Foundation, should I sell tobacco out of my office? It's ridiculous because it's defeating the purpose, and a pharmacy is the same way. They've asked for it as a self-regulatory body. If they believe in it, why shouldn't they have it out of their stores? Don't we all have some type of ethical values and stuff that we should adhere to as citizens of Ontario? I believe in that, and I think that goes for people in business.

**The Chair:** Thank you for coming to the committee this afternoon and for the written presentation as well.

1600

JIM SEMCHISM

**Mr Jim Semchism:** Good afternoon. My name is Jim Semchism. I'm an owner-manager of Ealing Pharmacy, a 1,500-square-foot, full-service drugstore that serves southeast London and has for the past 42 years. I received my pharmacy degree in 1978 from the University of Toronto. I worked for three years as a staff pharmacist for the Big V pharmacies group in the London area before purchasing Ealing Pharmacy from my father in 1983. Like Mr Robb and Mr Coulter, I'm an SOP; that's a son of a pharmacist.

There are eight pharmacists in my immediate family. They include my wife, my father, two brothers, a sister, a sister-in-law and a brother-in-law. I have a fair amount of experience with the profession and those people who work in it.

I'm a former president of the London and District Pharmacists' Association and the Ontario Pharmacists' Association. I'm co-chair of the Pharmacists in Support of Bill 119. Today I'm here to speak of my own personal experience in the discontinuance of the sale of tobacco in my own pharmacy and share my own personal perspectives on this issue.

I made headlines in 1986 when I was the first local pharmacist in the London area to stop selling tobacco products. Now 10 other London stores have followed my lead. I was in the news again in 1990, when I resigned from the Ontario Pharmacists' Association council over its position on tobacco sales in pharmacies.

I would like to thank the committee for allowing to me to address it in support of Bill 119. I would particularly like to congratulate the government for bringing forth such a comprehensive action plan at this time. In addition, I would like to praise the Health minister and the Treasurer for their position on high taxation on tobacco, in spite of challenges from Quebec and the federal government. The number one reason my patients have wanted to quit smoking for the past 15 years is the high



cost of this deadly habit. Removing taxes is an invitation to encourage new smokers, young people in particular, and established smokers to continue this bad habit. It's that simple.

Last week's headlines by Liberal governments in Ottawa and Quebec City were very disheartening for those like myself who have fought for years to create a smoke-free Canada. The health coalition's full-page ad in the *Globe and Mail* last week gave the Prime Minister the correct path to follow. Some of his caucus listened, but the majority went for the quick fix to appease Quebec store owners and law enforcement officers who did not want to confront the criminal element who defy the laws by smuggling tobacco.

Tax removal will lead to long-term government debts to pay for the medical costs of smokers and their innocent victims. I'm referring to environmental tobacco smoke. Most often, these powerless victims are children of smokers, trapped in their cars and homes. It sickens me to describe the injustice done to young people by their own parents. There are no laws to protect the unborn, the infants and young children of smokers, who have no option but to breathe in the secondhand smoke that is filled with carcinogens from their parents' cigarettes.

Every day I face the victims and smokers across my dispensary counter. Each parent who smokes is potentially consuming thousands of dollars of bronchodilators, anti-asthma, anti-hypertensive and cardiovascular drugs. Some are on chemotherapy as well. Most are also taking anti-ulcer medication and almost always are taking antibiotics and cough preparations on a regular basis. They remain addicted in spite of these conditions.

The sad part is that most of the smokers don't care about the costs of these therapies. "My employer pays for my drugs," they say, or, "The government drug plan covers the cost." These same people will be overjoyed by the fact that it appears now inevitable that tobacco costs will be dropping, as proposed by the Prime Minister.

Now let's look at the damage done to children by secondhand smoke. These children almost always face a high rate of asthma and bronchial infection. They live on Ventolin, steroid inhalers, antibiotics and cough suppressants. This causes them to miss school and puts them at risk for long-term complications as victims of secondhand smoke. I see the kids' bloodshot eyes. Their clothes reek of their parents' cigarette habit. It's a pitiful sight to behold.

The real shame is that many in my own profession and some members of this committee do not seem to understand that pharmacists and health facilities should not be involved in the sale of this legal poison. If any one of you had spent the last 15 years of your life treating the victims of tobacco, you would not be defending the tobacco industry or corporate pharmacies' interests.

This is one issue that should not be partisan. All three parties should support the government's bill, especially in light of the setback brought on by the Chrétien-Johnson alliance with the tobacco industry. Lysiane Gagnon's column in last Saturday's *Globe and Mail* outlines overt collusion that has taken place between the politicians and

the tobacco industry. We are dealing with the greatest cause of preventable death in the province. This should be motherhood.

Mr Robb spoke earlier. His father and my father were classmates. His father was a victim of lung cancer. The choice of removing tobacco from his store was relatively simple. Jeff lost his dad. My father and I lost a close friend.

At this point, I'd like to make an economic review of tobacco. I've photocopied my sales figures from my profit-and-loss statements—they appear at the back of my submission—from 1985 to the present. Actually, I think they go back to 1984.

You will note that tobacco was removed from my store in August 1986, so it was about three or four months into that particular year. My year end is April 30, and therefore tobacco was sold from April to July 30 in my 1986 statement. I am pleased to say that there was little or no negative results from the removal of this product from my store, no one lost his job, and I prospered in spite of not selling tobacco.

Tobacco represented about 11% of my sales in my last full year of selling tobacco, and I've dropped the numbers there. My annual sales in that year were \$907,000; \$101,000 of that \$907,000 was tobacco. This contrasts favourably with Mr Bloom's statement—Mr Bloom being the CEO of Shoppers Drug Mart who spoke to the committee last week—that tobacco represented 9% of his company's total retail sales. It doesn't matter that the average Shoppers Drug Mart sells \$4 million, of which \$360,000 represents tobacco; in my case, \$101,000 represented more to my business, it appears. With my business it was 11%; with the Shoppers group, they said 9%.

Mr Bloom criticized one of my colleagues, claiming that her tobacco volume was low and that that's why there wasn't a big impact by her ceasing to sell tobacco. Sure, every store is different. The Shoppers franchise agreement generates in excess of 10% on tobacco. There's obviously a vested interest in why they want to sell the product. It is no wonder that SDM is selling over \$1 million in tobacco in many of its stores. These stores are paying head office, if you look at the franchise agreements, in excess of \$100,000 per store for the \$1 million in tobacco sales.

Pharma Plus's president, Rochelle Stenzler, spoke to the committee last week, and she said something that was enlightening, that I didn't know. She suggested that tobacco is exempt in many of their percentage leases. This means that landlords will not be clawing back on lost tobacco sales in pharmacy. I was pleased to hear that. I wasn't aware that tobacco was exempt in many retail leases.

Here is my understanding of corporate tobacco economics. Most stores use tobacco to generate cash flow. Shoppers Drug Mart franchisees have told me that they sell the product several weeks before they have to pay for it. Tobacco, as anyone who's in the retail business knows, has the highest turns of any product in their store.

Now I'd like to look at the second-largest pharmacy



chain in the province. Ms Stenzler claimed in her submission to be number two because she has more stores than Big V, but I've always elevated Big V to be number two because they have higher sales than the Pharma Plus group.

Big V made a conscious decision in the 1980s to de-emphasize tobacco. Tobacco sales dropped from in excess of 10% of their sales back when I worked for them to less than 3% today. Their president is on record as supporting Bill 119. Contrary to what we heard earlier, I've got a Canadian Press clipping in my bag here that I would be happy to share with you that quotes Mr Puhl's exact remarks in supporting the bill. He was pleased that the tobacco bill created a level playing field among all pharmacy retailers. His company's philosophy is in sharp contrast to those other corporates who are in opposition to the bill.

I feel that the Pharmacists in Support of Bill 119 diffused the negative publicity of the Committee of Independent Pharmacists at the hearing last week.

1610

To summarize, hundreds of independent pharmacies have discontinued tobacco sales without serious economic hardship in the past eight years. In London, the majority of independents have stopped selling tobacco. There are 21 independents here in London and only five sell tobacco. Throughout southwestern Ontario, many large independent pharmacies have discontinued tobacco sales. Here in London the Wilton pharmacy, and in Wallaceburg the Jackson pharmacy are prime examples of large stores, 4,000 square feet or more, that have stopped selling tobacco products without serious consequences. I spoke to Mr Jackson this morning. He confirmed that he recovered his lost revenues and profits in under 18 months and that tobacco represented well in excess of 10% of his large store sales.

We anxiously await the enactment of this legislation. Our college announced in 1991 that July 1, 1993, would be the date of its implementation. The profession has gained almost a year's extra prep time. Many of my colleagues have voluntarily removed tobacco products in anticipation of the creation of this level playing field. They did not want to be embarrassed by having to follow a legislative directive. We owe them in good faith that the legislation, as proposed, be passed.

It is my understanding that Mr Barry Phillips, the immediate past president of the college, spoke to you on Thursday. Although I have not received the printed text of his remarks, it is unfortunate that he appeared before the committee condemning the actions of the college. One has only to look to his storefront to see what perhaps motivated his remarks. Mr Phillips is a lifelong Shoppers Drug Mart franchisee.

On the positive side, I'd like to make an interesting observation about some of the past presidents of the Ontario Pharmacists' Association. The last six of my colleagues, and I've put their names and their stores in the appendix, have either thrown tobacco out of their stores or never sold tobacco or worked for a company on record as supporting the ban. It seems to me that the leadership at OPA is leading the province in spite of

opposition put up by many.

As announced previously, I would like to share the current results of the Pharmacists in Support of Bill 119's membership drive and survey. There were 7,640 surveys mailed out. As of noon today, with a return rate of over 6%, and we expect to get a lot more in the next two weeks, membership numbers for the group stand at 317, and 391 respondents, or 81%, were in favour of the ban. That's 317 members who signed the survey, and we had 74 pharmacists mail in their anonymous consent or response to the survey. Approximately 89 respondents, or 19%, were against. These figures will be further updated by Nghia Truong when he speaks to your committee in Ottawa. I welcome your questions and comments.

**Mr Jim Wilson:** Thank you for your presentation. I'm a little disturbed by some of the attacks in it. I guess I'd have to say, with respect to my party's position against the ban, that clearly not all pharmacists agree with you. In fact, my survey result has a few more replies than yours to date, and 70% of those pharmacists felt that the NDP government should not be able to ban the sale of tobacco products.

The other thing I took exception to was on page 4 and throughout the presentation. It seems to me that if anyone disagrees with you, you simply discredit them. You discredit the only study that's by a firm that does a lot of the government studies that we actually have had presented to this Legislature.

I'd say to you, with respect, that our job is to represent perhaps both sides of the issue in the Legislature. The government clearly spelled out its side in the act and there are a lot of pharmacists who are professionals out there who are ethical people, who raise families, who do good things for the community and who disagree with your position. We're bringing that forward because I think people are tired of government and us going home on weekends and lecturing our constituents about what's good for them. They've kept throwing them out over the last decade and I suspect they'll throw this government out over this lecturing about what's good for them. I think people are prepared to take responsibility for their actions.

**Mr Winninger:** Question.

**The Chair:** Order.

**Mr Jim Wilson:** If society's wrong, it'll figure out it's wrong and ask its politicians to change eventually.

I want to ask you, though, given that the ban is in the legislation, do you have any evidence to present to this committee that it will reduce consumption? That's the goal of the legislation and we've not seen anything to suggest that the ban will do anything to promote the goal. We've heard it will do a number of other things, but we haven't heard anything concrete that it will actually promote the goal of the legislation.

**Mr Semchism:** Obviously, if I had a study that showed that was the case, I would certainly bring it to the committee. I don't have a study.

In reaction to your remarks about me being critical of the Coopers and Lybrand study, I think the 300 or 400 pharmacies that have thrown tobacco out of their stores

and survived speak a lot louder, and that was our group's position, that they didn't meet economic demise and some of them had big sales in tobacco. That's why I'm critical in my presentation today.

I recognize that many pharmacists want to sell tobacco products. It's been a divisive issue within our profession. You heard from people who were in opposition to me today and you heard from people who supported our position. We don't debate that. Today, I spoke personally. I just told you what I felt based on my experience of being a pharmacist.

As far as the difference in our surveys is concerned, I guess it's almost predictable. I received your letter and your card and I mailed it in, but I would think that probably the majority of people receiving your card, based on the text of your letter that went with it, who would reply to your survey would be against the government ban, just like, as I expected, the majority of people who would take the time to reply to the Pharmacists in Support of Bill 119, and the majority of those people replied in favour of the government.

There have been other studies. Perhaps the only ones we can trust are ones that are done by groups that don't have a vested interest. Maybe those kind of surveys are being done right now. I don't know.

**Mr Jim Wilson:** Just for the record, I wouldn't call either my survey or yours a study.

**Mr Semchism:** No.

**Mr Jim Wilson:** It was simply a public opinion survey, not scientific whatsoever, and I agree with your comments. I was surprised so many people sent it back.

**The Chair:** I regret that we're over our time. Thank you for coming and for the presentation.

1620

#### CENTRE FOR HEALTH PROMOTION

**Ms Josie d'Avernas:** My name is Josie d'Avernas. I'm a partner with RBJ Health Management Associates. I've been involved in research in the tobacco issue for 15 years, first as a university-based research associate and more recently as a private consultant based in Kitchener. I've taught smoking prevention programs to grade 6 kids in Oxford and Waterloo counties. I've been involved in focus group interviews with young people around tobacco use. Most recently, I've done some work with the University of Toronto on plain cigarette packaging and the response of young people to plain packaging.

I also have two sons approaching the average age at which young people start to smoke; one is 13 and one is 11. I care about the impact of this legislation on youth and I will focus my comments on young people.

I'm here on behalf of the Centre for Health Promotion, University of Toronto. I'm here primarily to discuss plain cigarette packaging and to urge the government to include, under section 5 in Bill 119, regulations to require that in Ontario cigarettes be placed in plain packages. I will give some highlights of the research that we have conducted to support the proposal that cigarettes be put in plain packs.

First I would like to say that the Centre for Health

Promotion supports all the components of the Ontario tobacco act. The combination of legislative components put forward offers a comprehensive and complementary mix of policies that will mutually support each other.

The Ontario government is to be congratulated for bringing this legislation forward and bringing it to third reading. It has the potential to be a very powerful piece of legislation and I think it's commensurate with the magnitude of the tobacco problem in Ontario. Of course, any legislation is only as effective as the regulations that go along with it and enforcement. I'll come back to that in a minute.

In order to truly reduce tobacco use in Ontario, it's essential that children be prevented from ever starting to smoke. The vast majority of onset occurs before the age of 20, 90% by some reports. If we can stop kids from starting to smoke before they are legally able to purchase tobacco, we can go a long way towards promoting a generation of non-smokers. On average, young people first try smoking at age 13 and start smoking on a daily basis by age 15.

A strong Bill 119 I think is especially important in the face of likely tax reductions in cigarettes proposed by the federal government. I am strongly opposed to those tax reductions. I applaud the Rae government for its resistance in supporting those tax reductions because it's our young people who will be the most negatively affected by these price reductions.

Studies on price elasticity of tobacco show that young people are more responsive to tobacco price than are adults. Studies in the United States and Canada show that for adults the average price elasticity was minus 0.4%. That means that a 10% increase in price will decrease consumption by 4% in the aggregate. For children, the price elasticity is minus 1.4%, a 10% increase in price leading to a 14% decrease in consumption.

All of these studies have been done on price increases, not on price decreases. Now we're in a unique position of price decreases, but I think it's safe to assume that some of the elasticity effects will be similar. That means that a 10% decrease in price can lead to a 14% increase in consumption, all other things remaining equal. If that's true, a cost decrease will quickly undo the significant gains and advances that we've made in recent years.

In the light of that, it makes Bill 119 even more important in terms of two things: making tobacco less appealing to young people and making it less available to young people. Bill 119 has the potential to accomplish both if there are appropriate and strong regulations supporting the bill. I will focus my comments on plain packaging as a way to make it less appealing, but I will touch a little bit on the issue of reducing availability of tobacco to youth as well.

My comments on plain packaging or reducing the appeal of tobacco come from the study recently released from the Centre for Health Promotion at the University of Toronto. Research is under way investigating the effects of plain packaging in a three-study series. Studies 1 and 2 are complete. They've been funded by the Canadian Cancer Society. Study 3 is in progress and it is being funded by the Robert Wood Johnson Foundation in the



United States. The research is headed by an advisory committee of researchers from the newly formed Ontario tobacco research unit, University of Toronto, York University and Ryerson Polytechnic University. My company was involved in a staff capacity to this committee. I was responsible for drafting the design of the study, implementing the protocol, data collection analysis and report writing.

The first study was interviews with tobacco control researchers and marketing experts to collect expert opinion about the role of advertising and promotion and package design in product use generally, and as it relates specifically to tobacco. This study concluded that youth are more image-driven than adults and that young people begin to smoke specifically to project a certain image. Where do these images come from? They come at least in part from the marketing strategies used by the tobacco industry to project smokers as independent, fun-loving, attractive and rich people.

Tobacco companies can't advertise their products directly, but they indirectly advertise through sponsorship of sporting and cultural events. That's their answer to promoting cigarettes in the face of a ban on direct advertising. You've probably all seen the du Maurier tennis and golf tournaments, the Matinée Fashion Foundation, Players car racing. All those are sponsored events by tobacco companies.

These ads in effect advertise cigarettes, although cigarettes are not shown or mentioned on them. The connection comes from the use of names, colours and fonts that are very similar to those used on the cigarette packages for that particular brand. If we were to put cigarettes in plain packages, the experts interviewed in our study 1 suggested that the connection between the cigarette and the sponsorship events will be lost.

In addition, plain packaging is unappealing in its own right. In the second study in this series, we showed young kids aged 12 to 17, 129 of them, packages of cigarettes. We showed them a regular package, bought off the shelf, of du Maurier cigarettes or Players or Craven A, and we showed them the same product put in a plain package where it's a buff-colour package with standard font used. The brand name still appears, the health warning still appears, but there's no colour, no unique font, no logos used on the package. These interviews were done in Peterborough, Barrie and Toronto.

We asked the kids to look at a list of words that would describe a person who would purchase a package like this and a person who would purchase a package like this. There was an equal number of positive and negative descriptors on this list. In addition, kids were allowed to add their own descriptors.

The words used to describe the user of the brand packages were invariably positive: "smart," "cool," "with it," "athletic," "buys the best," "fun," "popular," "always has the latest thing." Those were our words. We also allowed people to add their own words. They included "preppy," "rocker," "outgoing," "partier," "regular person," "well respected," "fun to be with," "cares about appearances."

We asked them to use the same list of words and describe a user of a plain package of cigarettes. The words

that came out here were quite negative, things like "wimpy," "gross," "boring," "a goody-goody," which is a very bad thing, "buys the cheapest," "geeky," "will try anything." Those were our words. The words the kids added were "loser," "dirty," "old," "out of it," "a '50s type person"—I don't see anything wrong with that—"nerd"; even "fat" came out as a descriptor, and "stupid," "no life," "desperate," "strange," "uninteresting." Very strong differences in the perceptions of users of these two different packages, and we were very clear in saying: "It's the same product inside the two packages. We're only interested in the package."

We also asked them to give us their direct reactions to the plain packages. All of the groups strongly disliked them. They saw the buff colour as even worse than white because buff says old or antique and white has a bit of a crisper look to it. They preferred the white to the buff, although we didn't show them packages in white. We only had this one version of the plain pack.

People also reported that it makes the product look more serious and that it increases the prominence of the health warning on the package. On the other hand, the brand packages were reported to make cigarettes and smoking look like fun.

We also put the two beside various different brands of cigarettes, in plain and brand packs, and asked them to indicate which they would least like to be seen with. Between 80% and 97% said they wouldn't want to be seen with this one; they'd prefer to be seen with this one.

#### 1630

These were focus groups of six to 10 kids that we did, 20 focus groups, 129 people in total. The results were very consistent across groups. Some of the kids were younger groups, 12- to 14-year-olds, and some of the kids were older groups, 16- and 17-year-olds: the same results. Smokers and non-smokers, same results; males, females, same results.

Our main conclusion from this research was that current packaging of tobacco reinforces the positive images of smoking by linking smoking to images of independence, fun and attractiveness, and those kinds of images are projected through promotional strategies. The package is a key link that allows these marketing strategies to succeed. If it was plain, if it did not include colours and fonts, the connection to this event-advertising that tobacco companies are using to promote their product would not be made.

Youth are also more influenced by these marketing tactics than adults because they're more image-driven. Also, youth are more likely to be in transitional stages of smoking, in other words, thinking about starting or experimenting, whereas adults are either confirmed smokers or confirmed non-smokers. Our research showed, particularly through the expert interviews, that this kind of packaging is likely to have a bigger impact on young people than it will on adults for those reasons.

Accordingly, to reduce the appeal of smoking to youth, we recommend that regulations under section 5 of Bill 119 require that tobacco be packaged in plain packages with black printing, standard fonts and no use of colour.



We also recommend that Bill 119 tighten controls on tobacco company sponsorship of sporting and cultural events—that's the other half of the equation—by banning the practice of using look-alike names, colours and fonts in advertising for these events.

Just a word on making tobacco less available. That was the appeal side. We can do something about making it less appealing for young people by changing the package. Cost is one of the factors making it available or unavailable to young people, but there are other controls as well as cost to make it less available to young people; specifically, effective controls on selling of tobacco to minors.

In the same study that I've been speaking of, over two thirds of the smokers we interviewed bought their own cigarettes, the most common location being a convenience store. Although retailers are breaking the law when they sell cigarettes to anyone under the age of 18, none of the people we interviewed had any trouble buying their own cigarettes.

We support Bill 119 in its proposition to increase the legal age of purchase to 19. We support banning all tobacco sales from vending machines. We support requiring proof of age to purchase cigarettes. We also urge you in Bill 119 to require licensing of retail outlets with enforcement and revocation of licence for selling to minors. We also encourage you to set a minimum package size of 20 cigarettes. Kiddie packs of 15 and even 5-packs have recently come on the market, and that makes smoking more affordable to our young people. This practice needs to be stopped.

**The Chair:** Thank you for bringing the results of your study to us. We'll have time for a few questions.

**Mrs Haslam:** I'd like to congratulate you because you're one of the few who have come to see this as an overall Ontario tobacco strategy and to see the piece of legislation as fitting into that overall strategy. I think people coming before us forget that it's a piece in an overall strategy. I also am pleased to see that you are of the opinion that it's only going to be as effective as its regulations and enforcement, because I fully agree with that. It's the enforcement that will make or break the success of any piece of legislation.

Regarding those points on page 1, and that's where I'd like to go to now, when you're looking at packaging, you know that we're going to have to be working with the federal government in an overall national strategy. I'll ask my questions in one fell swoop and maybe give you some time.

**The Chair:** The Chair favours fell swoops.

**Mrs Haslam:** The Chair favours fell swoops. Good. I'm so pleased.

Number one in my fell swoop is what role Ontario should play with the federal government in a national strategy for packaging.

The second thing is to look at tightening controls on the advertising of tobacco companies supporting—that would come under regulations. It could prove difficult and I'm open to hearing some suggestions. Coming from a ministry of culture, I know that in reduced times of money availability to theatres and to artistic groups, they

welcome that support. Would that support still be there if they couldn't do some of the font work, or do you think the support should still be there, and what would you recommend in how that support could be there and how you would take out some of the font work?

On the third point, you're requiring all retailers who sell tobacco to be licensed. Do you agree with the present model in the proposed legislation whereby we look at it under a ticketing process?

The last thing I wanted to ask is on study 3. When will the findings be in for that last study?

**Ms d'Avernas:** I'll try to address your questions to the best of my ability, the four or five that you've asked.

The role that Ontario should play in the national strategy: I think tobacco is a provincial issue as well as a federal or a national issue. Clearly, there has to be collaboration between the different levels of government, but I would hope that Ontario can provide some leadership in tobacco control. I don't think we're going to see it from the federal government, given what I've been reading in the papers over the last few weeks. I think Ontario can play a leadership role in tobacco control.

If we can maintain a strong Bill 119 and if we can demonstrate some effect of Bill 119 in combination with the comprehensive tobacco strategy under way in Ontario, the other provinces and the federal government will have to look at what's happening in Ontario. I hope that we will give the federal government and other provinces an opportunity to look at Ontario as a model for things they may do in the future.

In terms of tightening controls on sponsorship, will removing fonts and colours cause tobacco companies to withdraw from sponsorship? I don't feel that I can answer that question. I'm sorry.

**Mrs Haslam:** Would you still recommend it?

**Ms d'Avernas:** I would still recommend it even if funding was withdrawn. Yes, absolutely. I think that is one of the key links to the ability of tobacco companies to advertise at this time.

Number three, licensing: Do we support a ticketing system proposed in the bill? I would prefer a system where retail outlets are required to have a licence to sell tobacco and that licence can be taken away if they are caught selling to a minor so that the disincentive for them to do so is loss of revenue from being able to sell tobacco.

The findings from study 3: We just heard about funding for the study last week. It's beginning. Next week is our first advisory committee meeting, and we anticipate the results will be ready in December.

**Mr Jim Wilson:** Thank you very much for your presentation. Obviously, you spoke at great length about the need for plain or generic packaging and you gave the committee a description of what that packaging should look like. I think that's needed, because with all the media reports on this legislation, I can't figure out for the world why it got so much attention, this piece of legislation. If it wasn't for the pharmacy thing and perhaps the vending machine aspect, there's nothing new here.

**Mr Martin:** You wouldn't do it.

**Mr Jim Wilson:** Well, it's already the law of the land, most of this stuff. All they've done is boost the age by one year.

**Mrs Cunningham:** Do your research, Tony.

1640

**Mr Jim Wilson:** We don't know what the regulations are, and I don't know if you were in the room when I asked the government whether they were prepared to move in the packaging section, to tell us what in the world they envision there. They must know or you wouldn't ask for regulatory authority, I would hope.

It's a leading question, but would you agree that unless the government comes forward with its regulatory intentions, this bill doesn't really set us too far down the track of reducing consumption in Ontario? It sounds great. I read in the paper that they were going to ban kiddie packs, but I can't find it in the bill.

**Ms d'Avernas:** I think the strength of any legislation lies in its regulations and in its enforcement.

**Mr Jim Wilson:** So your preference would be that the government spell out as much as it can in this legislation so we actually know. If we're going to give it credit for a bill, we need to know more than just that every page says, "We're asking for regulatory authority to do X, Y and Z," but doesn't tell us whether they're actually going to do X, Y and Z, or if they do it, how they're going to do it or what it's going to look like.

**Ms d'Avernas:** My response to that is that I certainly support the spirit of the bill and I have some confidence that the government will put in regulations that equally support the spirit that's being reflected in the bill.

**Mrs Cunningham:** Could I just ask a question on the position of licensing? To license a retailer, which has been raised today, where do you see that taking place in the bill? Do you see it as part of the legislation or part of the regulations?

**Ms d'Avernas:** It's not in the legislation right now, so I guess I was seeing it as part of the regulations.

**Mrs Cunningham:** It's not in the legislation and we're in the position of making amendments. That's why I'm asking the question. It's got to be legislation, I think.

**Ms d'Avernas:** I would suggest that it be put right in the legislation in that case.

**Mrs Cunningham:** That's why we're having public hearings, to make recommendations for change. We don't expect it's going to look like this at the end of public hearings, or what's the purpose of the public hearings? I'm the eternal optimist or I wouldn't be doing this job.

**Ms d'Avernas:** Yes, I would support licensing.

**The Chair:** There's a sense of optimism in the hall as we move to the parliamentary assistant for a final thought.

**Mr O'Connor:** On the area of sponsorship, of course that falls under the federal legislation, Bill C-51. I'm sure you're quite aware of the Tobacco Products Control Act, and as you know, it's tied up in the courts right now. Would you like to comment—you've been involved in some of this earlier on—on the Trade-marks Act, which

falls under federal legislation. I don't know whether you're a lawyer or not or whether it would help for you to comment on the fact that the Trade-marks Act would also be a problem. It is federal legislation, which is why the packaging has to be dealt with from a federal level.

**Ms d'Avernas:** I can't respond to that. I'm not a lawyer. I'm a researcher. I can respond to questions in terms of the expected impact of these things. I can't answer on that.

**Mr O'Connor:** Fair enough. It's federal legislation, and I was just wondering.

**The Chair:** Thank you again for coming and sharing the results of your research with us.

**The Chair:** Our final witness today will be the representatives from the Wellington-Dufferin-Guelph Health Unit. We invite them to come forward.

**- Mr McGuinty:** While they're settling themselves here, the parliamentary assistant raises a good issue and I wonder if the researcher might assist us in this regard, to tell us the connection between the federal regulatory authorities and the provincial with respect to packaging and perhaps some of the history associated with it—I gather there was a court case which said that somebody had gone too far at some level, whether it was the province of Quebec or something—just so that we have a bit more information regarding that. I'd find that helpful.

**The Chair:** Perhaps research could have a look at just what's involved in terms of what would be possible to bring to members prior to clause-by-clause.

**Mr McGuinty:** Yes.

WELLINGTON-DUFFERIN-GUELPH HEALTH UNIT

**The Chair:** Welcome to the committee. What's the old phrase? Last but not least. We're delighted to see you, delighted that you have come from Wellington-Dufferin-Guelph. If you would just introduce yourselves and then please go ahead.

**Dr Douglas Kittle:** Since this is lighten up day, I thought maybe you might have a bit of appreciation of my red nose. At 4:30 in the afternoon, I'm sure you're pretty fed up hearing all kinds of discussion on this topic.

*Interjections.*

**Dr Kittle:** Great, but since it does wonders for my post-nasal drip, I think I'll remove it at this stage.

My name is Douglas Kittle and I'm the medical officer of health for the health unit, Wellington-Dufferin and the city of Guelph. On my right is Helen Kelly who is the program manager for the tobacco prevention program that we offer at that health unit. I'm sure, since I saw on the agenda that a number of other medical officers have already spoken to you today, that you have an appreciation of the work that we're in the business of carrying out.

I've been in Wellington-Dufferin for about two and a half years. Prior to that, I was the medical officer in Haldimand-Norfolk, which you are also probably well aware is one of Ontario's principal tobacco-growing areas. I don't know if anyone from the flue-cured tobacco association has spoken to you. I didn't see it on the



agenda, but I anticipated that they would have done a presentation today as well.

**Mrs Haslam:** They do it in other ways.

**Dr Kittle:** They're doing it in other ways, okay.

I would like to congratulate the NDP government, the two opposition parties, and in our situation, Mr Ted Arnott from north Wellington and David Tilson from Dufferin-Peel, both opposition MPPs, as well as Derek Fletcher—we've been in touch with all three of them and they're all soundly supporting this bill as it's coming forward—plus the Health minister, Ruth Grier, for tabling this most important piece of public health legislation. In fact, I would say that after legislation on pasteurization of milk back in the 1930s, this probably is the second most significant piece of legislation for public health since that time.

In the words of Dr Schabas, and I'm sure you've heard many of his words this afternoon: "Tobacco accounts for an enormous burden of illness and disability.... Tobacco-related diseases are the province's number one public health problem."

I am pleased to see many of the provisions in Bill 119 which directly affect young people's ability to gain access to tobacco products, and these include the introduction of controls on the availability of tobacco, including vending machines and pharmacies; raising of the legal age for buying tobacco to the legal drinking age, which is 19, as you all know; the banning of cigarette sales by licensed health care professionals, pharmacies and other health care institutional settings; opening the door for plain packaging, thereby eliminating the advertising vehicles of the tobacco industry, and that was well put forward to you by the previous speaker; increasing penalties for violations; and eliminating environmental tobacco smoke in many places.

I am delighted to see the inclusion of pharmacies as a place where tobacco does not belong. We are responsible in Wellington-Dufferin for the carrying out of this tobacco prevention program. In Wellington county, we now have 43% of our pharmacies which do not sell tobacco products; in Dufferin county, 58% are in that position.

During national non-smoking week, our Council for a Tobacco-Free Wellington-Dufferin presented awards to all the pharmacies which did not sell tobacco products. Many interesting comments came from pharmacists who either had never sold tobacco products or had stopped selling tobacco.

Bob Baxter of the city of Guelph's Kortright Pharmacy said, "First and foremost, I'm in the health profession and I don't find it good practice to promote sickness as opposed to health."

Don Sproule of Sproule's IDA Drug Store in Orangeville spoke about his tobacco-free move and had these words to say:

"I received recognition from my peers and other organizations.... I also received positive responses from my customers. However, I did not see as often many of my die-hard cigarette smokers who were going to quit when I stopped selling.... Positively, I gained many new

customers in the store.... I have a small pharmacy and by not selling smokes, I have freed up many linear feet of shelf space on which I can display and sell other products, almost all of which have higher margins. For example, my profit on a carton of cigarettes which sold for about \$45 was about a 5% markup. Also, I was able to divert several thousands of dollars to more profitable items.

"After I stopped selling tobacco the insurance company added on a premium for any store selling tobacco, and also a cap on the amount of loss they would pay for tobacco loss. I think this was about \$10,000. As we all know, making an insurance claim is very time-consuming, and one has to wait many months for their money. It has been almost two years since my store became tobacco-free. I know I made a correct decision. Everyone knows of the new legislation banning tobacco sales in drug stores. I feel tobacco should be banned from all retail stores."

When we actually asked him about follow-up on that, he was in favour of the licensing of retail stores.

1650

I believe that the debate over tobacco in pharmacies is really a conflict between the practice of pharmacy and the marketing interests of large corporations, which have little interest in health or in the wellbeing of the pharmacy profession.

I have difficulty comprehending that a pharmacist would knowingly sell a product which kills when used exactly as intended and dispense medication over the counter to help the individual quit smoking. We must ask, is this ethical? What is the message this sends to our youth? The message it sends is clearly unethical, and it says that money is the most important issue, not ethics and health.

I am concerned that the term "pharmacy" is not clearly defined in Bill 119, which will lead to some problems. In addition, "retail establishment" is also not clearly defined. I would recommend that the definition of pharmacy read as follows:

"Premises in or in part of which prescriptions are compounded and dispensed for the public or drugs are sold by retail, as well as all contiguous retail space, whether under common ownership or otherwise, within the premises and whether used for the sale of health care products or otherwise."

Omissions, and these are omissions which I would like the panel to consider if you are looking at changes to the current legislation: Although we have congratulated the government for its introduction of Bill 119, there are several omissions that need to be included in any comprehensive tobacco control legislation. These include the following. Now, I did put the first one on there, but chewing tobacco is mentioned in the bill, so I'll skip that and go to the next one.

There is no ban on the so-called "kiddie packs"; that is, packages of cigarettes containing fewer than 20 cigarettes, although it appears that a decision to ban kiddie packs could be made under the packaging regulations.



Here's a kiddie pack which I happened to pick up behind the Centre Wellington District High School in Fergus just on Saturday—it's an empty package—when I was walking the dog. For any of you who haven't seen it, I suggest that you pass it around and maybe when it gets to the end, it could be put in the ashtrays outside, because I have no further use for it.

There is no ban on the advertising and promotion of tobacco products. This is where plain packaging plays a very important role, and this could be done under the packaging regulation.

Public space restrictions on smoking do not go far enough to ensure that the public is protected from the effects of environmental tobacco smoke.

There is no attempt to improve the Ontario government's largely ineffective workplace smoking legislation. This is a glaring deficiency and one that the government has not indicated it will address.

There is no regulation in the bill regarding the storage of tobacco products at retail sites in order that they are inaccessible to the public until the time of sale. Counter-top displays are an incentive both to purchase and to shoplift.

In conclusion, our tobacco prevention team, the Council for a Tobacco-Free Wellington-Dufferin, and I believe that the inclusion of these measures and the enactment of a strong Bill 119 will set a world precedent and send a strong, clear message to everyone that tobacco is a hazardous, addictive substance and that the government of Ontario does not want the youth of this province to be victims to tobacco.

A strong Bill 119 will strengthen the credibility of the Ontario government, as it will further its promised commitment to preventive health care. Legislation like Bill 119 goes hand in hand with education and strengthens the message of all health agencies.

As a health agency which is predominantly in the business of giving out messages, we cannot do this alone. We need the assistance of this legislation and legislation like this. This is important from all angles. Municipal governments are telling us that they will not adopt a smoking bylaw because the federal and provincial governments are not doing their part. A strong Bill 119 will change this.

Our tobacco prevention team has been to the communities of Mount Forest, for example, and to the Fergus town council, where we have attempted to bring forward smoking prevention bylaws for the towns, and they have not had them previously. In both those places we were turned down, and we were turned down primarily because the politicians at the town councils and at the municipal level said: "What's the province doing? What are the feds doing? This is out of our jurisdiction." We recognize that these local bylaws are not out of their jurisdiction, but they're watching you very closely and looking for leadership.

Your support of this very important piece of public health legislation will send a clear sign to our young people and will greatly increase the chances for young Ontarians to be smoke-free.

**Mrs O'Neill:** I'm looking at page 4. It certainly is a page that contains an awful lot of information. I think it's important that as the last presenter of the day, you have very specifically pointed out a lot of weaknesses in the bill. I think in many ways the bill is not what some people think it is and I'm very happy that you were as concise as you were in pointing out the weaknesses. I hope some of these will be considered deeply in the regulations.

I wanted to ask you, just so I would be sure I understand, about the definition you've chosen for "pharmacy." That includes all of the chains and it would include Wal-Mart and A&P and K mart, those kinds of setups.

**Dr Kittle:** And Zehrs and Loblaw's.

**Mrs O'Neill:** I just wanted to be sure of that. I might say to you that two or three municipalities, mine being one of them, have been mentioned in the course of the hearings as municipalities that have taken a very strong stand.

This is a municipal election year. I really think, particularly with Bill 119, which I think needs to be strengthened—I don't think the bill's a strong bill, I really don't; I think it needs to be strengthened if it's going to achieve its objectives—it's time to put this on the political agenda and it's time to put it on the municipal election agenda, because you're right that there is leadership that is needed within the municipalities to accompany this bill. This bill is not going to achieve everything, and particularly the workplace and the secondhand smoke issues are being left totally as sidelines. We know how ineffectual those pieces of legislation are at the present time.

**The Chair:** Do you wish to comment, sir?

**Dr Kittle:** No, I agree with Ms O'Neill.

**Mrs Cunningham:** Thank you very much Dr Kittle and Ms Kelly. You're right, some of your colleagues have been here today.

**Dr Kittle:** Did they wear a red nose?

**Mrs Cunningham:** No, they didn't, but they had a good sense of humour just like yourself. I suppose that's important to your job from time to time.

Dr Heimann from the Windsor-Essex County Health Unit—I'm not sure whether you've met each other.

**Dr Kittle:** I know him, yes.

**Mrs Cunningham:** I would ask you to get a copy of his brief, and I'm certainly going to be referring yours to him. Maybe we'll take care of that ourselves.

He went a step further with regard to the plain packaging and the availability. He said that retailers should be licensed to sell so that there would be some responsibility on them to certainly get identification from young people who are purchasing cigarettes as to their age etc.

He also said that the responsibility should be on youth, that if in fact they're not to sell products to young people under the age of 19, then there should be some sanction on young people who purchase them, such as a fine or whatever. He did really take a very strong stand. I think in his area of the province, they're quite fed up with the lack of response from their municipalities and others with

regard to what you refer to as a need for some legislation in the province with regard to workplace smoking, secondhand smoke and whatnot.

I just wondered what you felt about licensing retailers, meaning that they have to have a license, and that there be certain restrictions and sanctions if they don't follow the law, and also with regard to the young people. How do you think your community would respond to that?

**Dr Kittle:** It's difficult to say how the community would respond, because I truly can't speak for the community. But I can say that I would agree with Allen, as it's interpreted through you, that we're dealing here with a deadly product and licensing for the retailer would be appropriate as it is for alcohol at the present time. If you're caught with a six-pack and you're under the page of 19, there are repercussions, because you are expected to have the responsibility for owning up to the fact that you're holding it. The same could apply for cigarettes as well.

**Mrs Cunningham:** I suppose it's up to us then, since we're not seeing either of these examples of strength in the legislation.

**Dr Kittle:** It could be added to it.

**Mrs Cunningham:** We'll have to make some amendments to it during that part on behalf of some of the presenters. We've already asked the government if it

would come forward with its intended regulations. If we haven't, I'm certainly asking it now, because this is my first day on the committee. It's easy to pass the buck to the federal government or to the provincial government on behalf of all levels of government, but I think we have a responsibility to show the lead here in Ontario.

**Dr Kittle:** I agree wholeheartedly and I'm very pleased to see that we're taking a good, giant step towards that lead. Let's not lose the momentum.

**Mrs Cunningham:** I'll pass your accolades on to Mr Tilson and Mr Arnott.

**The Chair:** We want to thank both of you and the red nose for coming before the committee. It was a good way to end the day's hearings.

**Dr Kittle:** Thank you, Mr Beer, and thank you for listening.

**The Chair:** Members of the committee, for those who are returning to Toronto on the bus, it awaits you. May I, on your behalf, thank everyone here at the hotel in London for making our stay a very enjoyable one. Perhaps Mrs Cunningham and Mr Winninger would pass that on within their constituency.

The committee stands adjourned until 10 o'clock tomorrow morning at Queen's Park.

The committee adjourned at 1703.





## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

**\*Cunningham, Dianne** (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

**\*Martin, Tony** (Sault Ste Marie ND)

**\*McGuinty, Dalton** (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Haslam, Karen (Perth ND) for Ms Carter

Sutherland, Kimble (Oxford ND) for Mr Owens

Winner, David (London South/-Sud ND) for Mr Hope

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gardner, Dr Bob, assistant director, Legislative Research Service

# CONTENTS

Monday 7 February 1994

<b>Tobacco Control Act, 1993, Bill 119, Mrs Grier / Loi de 1993 sur la réglementation de l'usage du tabac,</b>	
projet de loi 119, <i>M<sup>me</sup> Grier</i> .....	S-869
Bob Riepert .....	S-869
Huron County Health Unit .....	S-870
Dr Maarten Bokhout, medical officer of health	
Council for a Tobacco-Free Ontario, southwest region .....	S-872
Isabel Hill, representative	
Tiffany Major, elementary school student	
Middlesex-London Health Unit .....	S-873
Dr Verna Mai, associate medical officer of health	
Mary Ann Morgan, director, information resources	
Council for a Tobacco-Free Lambton .....	S-876
Cathy Bourke, member	
Windsor-Essex Council on Smoking and Health .....	S-878
Elizabeth Haugh, chair	
Scott Coulter .....	S-880
Windsor-Essex County Health Unit .....	S-883
Dr Allen Heimann, medical officer of health	
London Council of Home and School Associations .....	S-885
Janet Andruchow, president	
Canadian Cancer Society, southwestern region .....	S-886
Susan Cornish, chair, health promotion group	
Sarah Fielding, high-school student	
Sid Steinberg; Francis Mokenela .....	S-888
Lung Association, London and Middlesex .....	S-891
Bill Murphy, president	
Brent Keeling, honorary Christmas Seal chairperson	
James Belton, executive director	
Jeff Robb .....	S-894
Willy's Coin Machines .....	S-896
Willy Schmitchen, owner	
PST OFF ASH, Puff Out Campaign .....	S-898
Dr Terry Polevoy, founder	
Rick Bebenek, high-school student	
Heart and Stroke Foundation of Ontario, London-Middlesex chapter .....	S-900
Brendan Murphy, area coordinator	
Jim Semchism .....	S-902
Centre for Health Promotion .....	S-905
Josie d'Avernas, representative	
Wellington-Dufferin-Guelph Health Unit .....	S-908
Dr Douglas Kittle, medical officer of health	

CAZOM  
XC 12  
-577

Document  
Publication

S-34



S-34

ISSN 1180-3274

**Legislative Assembly  
of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

**Tuesday 8 February 1994**

**Journal  
des débats  
(Hansard)**

**Mardi 8 février 1994**

**Standing committee on  
social development**

**Tobacco Control Act, 1993**

**Comité permanent des  
affaires sociales**

**Loi de 1993 sur la réglementation  
de l'usage du tabac**

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott





### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. Sent as part of the television signal on the Ontario parliamentary channel, they are received by a special decoder and converted into data that your PC can store. Using any DOS-based word processing program, you can retrieve the documents and search, print or save them. By using specific fonts and point sizes, you can replicate the formally printed version. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Ces documents, télédiffusés par la Chaîne parlementaire de l'Ontario, sont captés par un décodeur particulier et convertis en données que votre ordinateur pourra stocker. En vous servant de n'importe quel logiciel de traitement de texte basé sur le système d'exploitation à disque (DOS), vous pourrez récupérer les documents et y faire une recherche de mots, les imprimer ou les sauvegarder. L'utilisation de fontes et points de caractères convenables vous permettra reproduire la version imprimée officielle. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 8 February 1994

The committee met at 1005 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

## HALTON REGIONAL HEALTH DEPARTMENT

**The Chair (Mr Charles Beer):** Good morning. It's Tuesday and we're back in Toronto, I think. Our first witnesses this morning are the representatives from Halton regional health department. Welcome. We understand the roads are not that great, so our 11:15 deputation will not be coming from around St Catharines; evidently the road has been closed south of Hamilton.

**Ms Sandra Murphy:** Everyone on the agenda in front of you is here today, and they include Yvonne Everard-Parr, tobacco use prevention officer, and Peter Willmott, director of health protection. They won't be presenting, however.

The Halton regional health department appreciates the opportunity to address the committee in support of Bill 119. I've brought with me today six students from Milton. They are smokers, and I will be asking them to speak to you shortly.

I'm a public health nurse. My name is Sandra Murphy and I'm assigned to three high schools in the town of Milton. I'm here to talk to you today about the youth of Halton and the problem of tobacco use.

According to the chief medical officer of health in his report on youth, Opportunities for Health, 22% of youths 12 to 19 years of age now smoke regularly. Male and female rates in the province are virtually the same. While there are no comprehensive statistics for the region of Halton, the Ontario Health Survey did compile statistics for the central west region of the province, and those statistics are similar to provincial statistics.

Several surveys of students attending Halton high schools have been done, and the findings from the Halton surveys reflect the provincial and regional statistics. Young people under the age of 18 are smoking and they are purchasing their own tobacco.

You have in front of you the brief that we presented. Some of the regional surveys are in that brief. I'd like to speak to the one that was done in Milton in January of this year. It was a particular Milton high school and we surveyed 634 Milton high school students. It showed a smoking rate of 26.1%, and that is four percentage points higher than the regional or provincial average.

The majority of the young smokers in this survey told us that they are able to buy their own cigarettes. Some 60.3% of 14-year-olds, 67% of 15-year-olds, 86.4% of

the 16-year-olds and 100% of the 17-year-olds surveyed were able to purchase their own cigarettes. Youth in Halton are clearly beginning to smoke and have access to cigarettes at an early age.

The Halton regional health department would like to suggest three amendments to Bill 119. I would like to read those recommendations to you after you have had an opportunity to listen and talk to the group of young smokers.

These students attend E.C. Drury High School and Bishop Paul Francis Reding Secondary School in the town of Milton. They will introduce themselves, present their experiences with tobacco and allow for questions.

**The Chair:** Would you mind just putting those recommendations on the record now, just in terms of time? That way we won't have to keep worrying, "Are we running out of time? We still need to get that in."

**Ms Sandra Murphy:** Certainly. The Halton regional health department fully endorses the provisions of the proposed Bill 119 and would like to suggest the following amendments: in section 3, that the type of identification required by youth to prove age of majority be specified; in section 9, that "amusement arcade" be included as a place where smoking should not be permitted; and in section 13, that the wording in subsection (1) be changed to read "will appoint" from "may appoint."

Thank you again for allowing us this opportunity to speak in support of Bill 119. We congratulate the government on introducing this important piece of public health legislation and congratulate also the opposition parties for their support of it.

**Mr Kian Higgins:** My name is Kian Higgins. I'm 19 years old. I've been smoking since I was 14. I was buying cigarettes for myself at that time. I'd buy them from retail stores, and when I was 16 I could go to pretty much any store. I've been asked for ID once or twice since I've been smoking.

**Ms Jenny Kang:** My name is Jenny Kang. I am 16 years old. I have been smoking since I was 14. I attend Bishop Reding high school and I find that there's no trouble in obtaining cigarettes. I'm rarely asked for ID.

**Mr Daryll Gordon:** My name is Daryll Gordon. I'm 18 years old. I've been smoking since I was 17 and I have had no problems at all getting cigarettes. They don't ask for ID or anything, anywhere.

**Ms Annie Stokan:** My name is Annie Stokan. I attend Bishop Reding high school. I'm in grade 11. I'm 16 years old right now. I've been smoking for about a year and I find buying tobacco products is no problem. We have smugglers that are able to bring them in to us and it's no problem at all to go to retail stores.

**Ms Bobbi MacNeil:** Hi, my name is Bobbi MacNeil. I am 17 years old. I've been smoking since I was 13 years old and I've been asked for ID maybe once since

I've started. I don't find that there are problems going to stores at all. I never get ID-ed for it.

**Ms Katherine Verge:** Hi, my name is Katherine Verge and I attend E.C. Drury High School in Milton. I'm 18 and I've been smoking since I was 14. When I first started smoking, I noticed that I could go anywhere and I wouldn't get ID-ed. I find that the easiest places to get it are convenience stores, whereas the hardest places are grocery stores and Shoppers Drug Mart.

I especially notice that the smuggling—I know even at our town, it's a very small town and it's very easy to get. Whether it's the schools or it's on the street, it's extremely easy to get it.

I've noticed, at least through my experience, that in the past year I've gotten ID-ed more than I had when I first started smoking, when I was 14 and 15. Now that I'm 18, I find that more people are more aware and that I've been getting ID-ed more than I had been when I first started.

**The Chair:** I think we'll have a good number of questions here. We'll begin with Mr Wilson.

**Mr Jim Wilson (Simcoe West):** A big thanks to all of you for appearing before the committee. This is the first time we've had a string of smokers appear before the committee, and it's a very interesting presentation as a result. In fact I don't think we've had any smokers appear before the committee.

**The Chair:** At least not who have admitted it.

**Mr Jim Wilson:** Not that they've made a point of telling us about anyway.

I'd be interested to know your thoughts on the following, and that is that we've been floating around the idea that perhaps we should make the possession and smoking of cigarettes under the age of 19 or 18 illegal, much like alcohol.

The reason we've been floating that idea around from opposition parties is that clearly, and your own testimony here today shows us, the current model really isn't working. The current model is that the onus and the responsibility is on the retailer, the Becker's store clerk who sells you these things. There are heavy fines under this legislation. There are fines now in existence, and they don't seem to be working.

Perhaps we should put some responsibility on young people and make it an illegal product under a certain age. We would have to sort of phase it in, say five years from now, because we know there are a number of young people under the age of 18 now who are addicted and you just can't stop them cold turkey—it would be cruel and unusual punishment I think in our society—but at some point the government announce that in five or 10 years it will be illegal to smoke under a certain age. What do you think of that idea, anybody?

**Mr Gordon:** I feel that there are more important things to worry about than catching kids smoking. There's nothing you can do. No matter what you do to stop them from smoking, they'll always get it. Whether they steal it from their parents, whether they get someone to go in and buy it for them, they're always going to obtain it somehow. There are more important things to worry about in our society than catching young kids

smoking. You have drugs running through society like a fire, you know. Pay more attention to more important things than smoking.

**Mr Jim Wilson:** Does it bother you at all that when you go and purchase cigarettes under the age of 18, under current law, you're putting that store in jeopardy? Under this law, they could lose their right to sell cigarettes for up to six months and there are heavy fines. Does that cross your mind at all? I'm not sure it would've crossed my mind when I was 18 or under, but—

**Ms MacNeil:** I think it's their responsibility. It's up to us too. I mean, it's our decision whether or not we're going to smoke. If we go to the store, it's up to them to refuse us.

**Mr Jim Wilson:** Okay. You don't think you should take any responsibility for that?

**- Ms MacNeil:** No.

**Mr Jim Wilson:** Do you agree that retailers should be punished because you're demanding cigarettes?

**Ms MacNeil:** Yes, because they can refuse us if they wanted to.

**Mr Jim Wilson:** But you'll just go somewhere else.

**Ms MacNeil:** Yes.

**Mr Higgins:** I think we should be punished, the person; also the retailer. I used to go in and when I got cigarettes, I'd feel like a big man. I'd go in and get a pack of cigarettes: "I look old. I got a pack of cigarettes."

**Mr Dalton McGuinty (Ottawa South):** I gather that all of you are still smoking, notwithstanding these piles of evidence that it causes you harm. One of the things we have to consider is the practical implications of the legislation. If we're going to prohibit smoking on all school grounds, what's going to happen to you? What will kids who are smoking now do?

**Ms MacNeil:** I don't think it'll stop; I don't think it'll stop at all. You're going to do it whether or not they say you can.

**Ms Verge:** Whether people are smoking in their cars or whatever, it's not going to stop. At our school, since the grounds are so large, there are designated areas where you can smoke. There's one designated area, but no one listens to that; people smoke anyway. Whether people are smoking in their cars or they're hidden behind a tree or whatever, people are still going to smoke. They're not going to listen to that, because they believe you're outside, you have the choice to smoke, especially if it's after school. People don't listen even more when it's that time of the day.

**Mr McGuinty:** What you've got here of course, you've got a bunch of adults sitting around who've dreamed up an idea on how to make it harder for kids to stop smoking. Maybe we should ask you. I shouldn't call you kids; I guess young people. If you wanted to make sure your younger brothers or sisters or people coming up through the ranks don't start smoking, what would you do?

**Ms Verge:** It really upsets me in many ways that a lot of publicity that gets people smoking is aimed at young people. I've noticed because I'm a female, and I know



there are more female smokers, that a lot of the things are aimed at young females. At that time, when you're 14 and you're getting into high school, you want to fit in so badly, and I think a lot of it is aimed towards people around that age. What they first have to do is stop that right there, because I don't think when you're 13, you're like, "Oh well, maybe I'm not going to smoke because it's 19." I don't think that will have an effect on people starting to smoke at that age.

**Mr Higgins:** I think it will; I agree with you. I'm trying to quit. I've been smoking for five years, and I think you've got to impose all the legislation you can, because when you're a young kid and you're not allowed to smoke at school, you know, you're not going to smoke at home. You've got to start somewhere. You can't start with the older people, so you've got to start young.

1020

**Ms Kang:** I think it's more of a challenge. The more you put up rules, the more rebellious teenaged people will get. When you're young you want to fit in and you're going to do the most outrageous thing to get attention, so you might just go walk around the school property and you'll see a group of teenagers smoking.

**Mr McGuinty:** Just one final question, please: Have any of you bought cigarettes from vending machines, particularly inside a bar?

**Mr Higgins:** Yes.

**Ms Kang:** Yes.

**Mr McGuinty:** You've been in bars underage too? Where's the parliamentary constable, Mr Chairman?

**The Chair:** Sorry, this is all being taped. The parliamentary assistant.

**Mr Larry O'Connor (Durham-York):** I appreciate your coming before the committee. I suppose when I was your age I was one of the ones standing in the designated smoking corner, and at that time it wasn't unfamiliar to see teachers join us there. It took a long time for me to quit, I think probably about six attempts.

As you know, the government isn't trying to legislate that there be a cessation right across the province for people to quit smoking, because we can't do it alone. The strategy involves working with the public health units, working with the community groups out there like the Lung Association, the Canadian Cancer Society, the Heart and Stroke Foundation of Ontario and a number of other people out there working on it.

Especially during National Non-Smoking Week I've gone into a lot of classrooms and talked to kids younger than yourselves, probably around the age when some of you said you started smoking. If you had something to say that could be directed to the Minister of Health, who will be watching this no doubt with keen interest, that would help us in our strategy to keep young people from becoming addicted to a habit that kills 13,000 Ontarians every year, what would you say? Would it be plain packaging, would it be restricting, would it have helped if someone had asked you for identification every time you tried to buy cigarettes? What would be the key? I'd ask if you could all have a quick response for that I'd appreciate that.

**Ms Kang:** I'd say it's advertisement. It's mainly focused on young people anyway.

**Mr O'Connor:** Plain packages?

**Ms Kang:** No, it doesn't make a difference. All the brand names are known anyway.

**Mr Higgins:** No.

**Ms Kang:** I would say so.

**Mr Higgins:** I think it's a matter of style, you know, the brand you smoke. It kind of defines your persona.

**Mr Gordon:** Stand by your brand.

**Ms Kang:** Yes, but that's a brand, not the packaging. It's the brand name.

**Mr Gordon:** Then it wouldn't matter.

**Mr Higgins:** If they're all the same packaging—

**Ms Kang:** But that's even more of a reason to say, "Look, I smoke Player's." It doesn't matter what it looks like; you just say that you do.

**The Chair:** Sounds like the Legislature.

**Mrs Karen Haslam (Perth):** I was enjoying it. Could you let them go on a little longer?

**Ms Verge:** I also believe it's not just the age that will make people stop smoking. I think what's going on right now with all the publicity, yes, that's going to also help people to stop smoking, but I think that it won't make a difference whether it's 18 or 19 unless in the store you're forced to show not even a birth certificate, because anyone can show a birth certificate, whether it's photocopied or not; it has to be even stricter than that, whether it's photo ID or three pieces of identification. It has to be something along the lines of that rather than just having to show a birth certificate, because if it's just a birth certificate, just because it's 19, people can still show identification and it still won't make a difference.

**Mr O'Connor:** What would you say, as a smoker, to your younger brother or sister, if you have one—I have six of them under me still—that would convince them not to take up smoking?

**Ms Verge:** I don't think there is really anything that you can say. I think it's just one of those things that they have to learn on their own. I know through past experience I was taught, you know, "Don't try it, don't try it; it's wrong, it's wrong." That's why I did it. What is so wrong about this? Why is it so bad? Why should I not try this? So then I was like, "I've got to try this," and that's how it started, with just wanting to know what it's all about. Then it started socially and then one morning I woke up and I was shaking, and I'm like, "Whoa, I'm hooked." I think that's a lot of it. It does start that way, that you're just interested and want to know what it's all about.

**Ms Stokan:** I have a younger sister and she knows I've been smoking for a while now and she sees how it's affecting my health. I've been more easily catching colds and stuff like that and she'll give me lectures, even though she's younger. She realized for herself that it's not the thing to do. She's 14 years old. I just think you have to come up with it yourself. Nothing anyone says to you will really change your mind. If you want to do it, you're going to do it. If not, you won't.

**Mr O'Connor:** I wish you all well when you get to the point where you decide that you want to quit, because it's very hard to quit. It took me six attempts. I hope it doesn't take you that many attempts. The longer you smoke, the harder it's going to be, believe me. Thanks for coming.

**The Chair:** All of you, as it was said at the beginning, are smokers and I assume you have been working with the Halton regional health department and its programs around getting people to stop smoking. The gentleman at the end said he was trying to stop. Knowing what you know now, going through this sort of program and working with the regional health department, are you all trying to stop?

**Mr Gordon:** No.

**Ms Verge:** No.

**Mr Gordon:** I have no desire to stop, personally.

**Mr McGuinty:** You must be a rich man.

**Mr O'Connor:** It takes a while.

**The Chair:** I just think those are things we need to know and I just wondered where you were in terms of what you plan to do.

**Mr Gordon:** I agree with what Annie said because both my parents smoked and I was totally against it when I was younger because I was into sports and I did all athletic, and it just happens. One day it just happens and it's just like a chain. It starts small and then you're in before you even know it. So there's nothing anyone says that can make you not want to try it or not do it. It just happens.

**The Chair:** I'm sure we wish we had more time this morning but I'm afraid we have to draw this to a close. Did you wish to just add any final thought?

**Ms Sandra Murphy:** I was just going to comment on what is happening in some of the schools. We are working with smokers, we've invited them to be a part of organizing the school environmentally and looking at policies within the school that help smokers to cut back or to quit. So smokers are coming on board. There are some kids who are ready to stop and some kids who aren't yet. Thank you very much for having us.

**The Chair:** Thank you for coming. We appreciate it.

#### HALTON COUNCIL ON SMOKING AND HEALTH

**The Chair:** I then call on our next presenter, the Halton Council on Smoking and Health. Welcome to the committee.

Can I just note again, for those members who arrived a bit late, that the 11:15 appointment will not be here because the roads are closed out in Hamilton.

**Ms Joyce See:** Thank you. We almost had the same problem. My co-presenter was a little caught up in traffic.

My name is Joyce See. I'm the chairperson of the Halton Council on Smoking and Health. This is Edith Telford. She's a volunteer with the Halton council and has been with the Halton council since it started 10 years ago.

The Halton Council on Smoking and Health is an interagency council made up of community organizations

and volunteers like Mrs Telford. Our member organizations are the Addiction Research Foundation; both of the boards of education in Halton, the Halton public and separate school boards; the Halton regional health department; the Heart and Stroke Foundation of Ontario; the Lung Association, Halton region; and the Canadian Cancer Society, Oakville, Burlington, Halton Hills and Milton branches.

The Halton council got together initially to plan activities for National Non-Smoking Week and World No Tobacco Day. Our council, because it has been around for about 11 years, has had other projects where we've tried to address tobacco issues. The primary one I think was that the council worked for about two years developing Project Smokefree, which was a consolidation of resources for teaching tobacco prevention in the schools. It's a package that's been used throughout Halton and it's been used by other organizations as well. We're fairly proud of that. We're at the point of evaluating that project. It's about five years old.

I'd like to introduce you to Edie Telford. She's been a volunteer. She's a retired kindergarten teacher. She's going to hopefully give the committee some of her experiences with tobacco use and talk about one of her kindergarten classes. Hopefully that will reflect some of the statistics that you've probably been hearing about the tobacco problem itself.

#### 1030

**Mrs Edith Telford:** My name is Edith Telford. Joyce has said this all before but I've been a volunteer for the cancer society for 12 years and a member of the Halton Council on Smoking and Health for 10 years.

I taught kindergarten in Oakville from 1960 to 1981. During that time, I guided about 1,000 children through their kindergarten year. The children in those first classes would now be about 39 or 40 years old. This is a picture of one of the first classes that I taught kindergarten, and I'll talk more about it later. First, I must tell about my own experiences with the problems of smoking which encouraged me to become a volunteer health educator.

I started smoking as a teenager. I followed the example of my best friend, who thought that if she smoked she'd be a big shot. I thought, well, if she smokes, I'll smoke. Anyway, after a while I went to normal school and taught school for two years and then married. My husband went overseas in the Second World War and when he came home we thought we'd like to have a family.

After two miscarriages I decided that I might have better luck if I stopped smoking, which I did, cold turkey. In two months my weight jumped from 92 pounds to 107 pounds. That's because instead of smoking, I ate. I remember one evening eating chocolates—

**Interjection:** And drinking beer.

**Mrs Telford:** Drinking beer? If you can imagine how that would taste. Anyway, 15 months after that our son was born and he weighed eight pounds, and 20 months after that another son came along and he weighed seven and a half, so I must have done something right. They were healthy little guys with lots of energy. But no one had ever told me about the relationship between smoking



and miscarriages, so I had to find out for myself.

When the children were both in school I went back to teaching, this time as a kindergarten teacher. A year later my husband died of a heart attack. His doctor had never told him that smoking was a danger to his health.

I felt very sorry for myself and foolishly started smoking again. By the time my elder son was in his teens I realized that he was smoking, so of course I thought what a horrible example I'd been setting and I quit again. Now, it took a little longer that time, but cold turkey again. It didn't help my son, he was hooked, but my younger son and my new husband were glad that I had chosen that route. Neither of them has ever smoked.

Now, back to the picture. The students in this picture would have graduated in 1974. According to the national statistics of that year, 55% of the boys and 38% of the girls between the ages of 12 and 19 years would have been smokers. These are represented by the faces with the red dots. They don't have a dot on me. I wonder what I was.

Further statistics tell us that 18% to 20% of smokers will die from related causes like lung cancer, heart disease and emphysema before they reach the age of 70 years. These are represented by the faces with the blue dots. Actually, there's blue on the red dots. Those are the ones who will die by the age of 70.

It saddens me to think that so many of our young people have started a habit which will be so difficult to stop. It is my hope that Bill 119 will go a long way to discourage tobacco use by our young people.

**Ms See:** The Halton Council on Smoking and Health, in our submission to you, has made a number of recommendations for amendments to the law, the first reiterating what the health department has mentioned about proof of age, so some kind of a photo ID. We think that's essential to be able to tell at what age kids are smoking.

In section 4, talking about the retail establishments, some kind of stipulation about licensed establishments: Three of our communities have it in municipal bylaws that licences are required to sell tobacco. The fourth doesn't. So virtually any place in the town of Halton Hills can sell tobacco because there are no restrictions.

Also in subsection 4(3), there's mention of the restriction of pharmacies etc coming in one year after the law is passed. That seems to be much too long a time. In the vending machines section, they've talked about three months as being the time. Three months seems to be a reasonable time to allow for stock to clear out etc and to make an adjustment. That would be a recommendation.

On the packaging and health warnings section, the Canadian Cancer Society study that talked about the impact of packaging on youth, the identification with a brand etc, we support the findings of that study and would recommend that if there is a change to packaging, that perhaps the change should be to the buffer-white packaging.

Under the controls relating to smoking, section 9, we would recommend that "a prescribed place" perhaps be a place that's ventilated to the outdoors, so that smoking only be allowed in places that are ventilated.

Subsection 9(2) talks about smoking in school property. If it could be extended to on school property, in Halton we're fairly lucky that both of our boards of education have chosen that there is no smoking—they have policies that says there's no smoking on school property—but I understand that there aren't many boards that have that policy. That should be extended.

Again in section 9, if there could be an addition of amusement arcades, and I think the health department talked about this a bit, we would concur with its recommendation and its definition for amusement arcades, the rationale for that being that youth are the target of arcades and youth are mostly the people who frequent arcades. If we support the legislation and have 19 as the age when smoking's permitted, then 19 is probably about the age that the kids are going to arcades. They shouldn't be allowed to smoke there.

Then the final recommendation we have pertains to the inspection, and a request that the wording be changed from "the Minister of Health may appoint inspectors for the purposes of this act" to the "the minister will."

I think from what you've heard from the youths who preceded us here today, enforcement is the key. If we can make it so that the laws that we have in place are enforced, then I think that we'll go a long way to stopping children from starting to smoke.

I have a 20-year-old son who's been smoking since he was 14, and it distresses me that so many of the health implications are going to affect him. I know they're going to affect him and, as a parent, it's a difficult thing to see. I thank the committee for their time.

**The Chair:** Thank you. The parliamentary assistant just had one point of clarification.

**Mr O'Connor:** You stated, on subsection 9(2), you want to expand it to include the school property?

**Ms See:** Yes.

**Mr O'Connor:** We're using, from the Education Act, the description of school, which includes the property. I would hope that maybe legislative counsel will note the concern that's being raised here, and we can take a look at that, but the intent was to include the school property as well.

**Mr Jim Wilson:** Thank you for your presentation. You mentioned that some municipalities in your area have a licensing system in effect. I'm just wondering, what is the result of the retailer compliance in those areas?

**Ms See:** My understanding is that all that's required is that annually a licence renewal is sent out from the municipality to the retailers, and I think it's \$10 or \$15 that they have to pay for a licence. If there's a complaint, then we've negotiated with one of our municipalities that this complaint about selling tobacco to minors could impact on the subsequent year's renewal of that licence. That's all there is so far.

**Mr Jim Wilson:** To the best of your knowledge, have licences been revoked?

**Ms See:** Not to my knowledge.

**The Chair:** I'm sorry that time is going to mean we



have to end, because with all the students I allowed a little more time there. I think your position was very similar. We want to thank you, and particularly for the personal experiences. Thank you again.

1040

JAMES GAY

**Mr James Gay:** Mr Chairman and honourable members, thank you for meeting with me this morning. I'll be brief with my comments on Bill 119, the proposed Ontario Tobacco Control Act.

My name is James Gay, manager of long-term care pharmacy services with Pharma Plus Drugmart, working out of our head office in Mississauga. I've been registered as a pharmacist in Ontario since 1983 and came into the office in 1988 after five years as a retail pharmacy manager with our company.

In the next few minutes, I will outline my position on Bill 119, especially section 4(2)8, the proposed ban on tobacco sales from drugstores.

First, I would like to applaud the government's efforts to reduce the tobacco use in our province. I've been quite impressed with your public messages on the subject. My wife and I were at a theatre on Sunday taking in a movie and one of your messages appeared before the movie started. It was concise and extremely effective in getting the message across. Again, I was quite impressed.

The strategic objective of discouraging children and adolescents from starting smoking, reducing overall tobacco use and decreasing public exposure to secondhand smoke is admirable and, I feel, obtainable with suitable public education. However, I do oppose section 4(2)8 since it is excessively punitive and inflicts unfair hardship on our segment of the retail industry without having any effect on the government's objectives I've just outlined.

Shifting distribution out of drugstores will actually diminish the control government has over the sale of tobacco to minors, which is one of the main intentions of the legislation. I was quite surprised at some of the remarks I heard this morning. It was very educational.

Under section 4(2)8, sales will be removed from an area which is highly regulated, secure and responsible. Taking tobacco out of drugstores will move sales of this legal product into outlets which are not as regulated, secure and responsible. A report by Lindquist Avey Macdonald Baskerville, which was presented to you last week, demonstrated that if people can't buy cigarettes in drugstores, they will simply buy them elsewhere, thus supporting my previous comment on shifting distribution. Again, it was reinforced by some of the comments made by the students this morning.

If the government wants to ban the sale of tobacco, it should do so, although you and I all know that this would be next to impossible. The fact of the matter is, stopping selling tobacco in all retail outlets altogether—place it into government-controlled outlets like an LCBO or a TCBO, if you will, but don't simply prevent one kind of retail outlet from selling this product and not the others.

It has been stated by proponents of this bill that it is unethical for a pharmacist who is a health professional to

sell tobacco products, that sale of these products is contradictory to our role as a member of the health care team. I feel that as long as tobacco is a legal product, then it should be up to individuals to make that decision as to whether they purchase tobacco products. All anyone can do is try and educate the people as to the dangers of their decision to smoke.

Pharmacists who decide not to sell tobacco are making a decision to be a corporate censor. That is their decision. A pharmacist who decides not to be a corporate censor is no less ethical. He or she is just allowing the consumers to make their own choice.

Furthermore, I do not think it is the government's role to legislate ethics. I feel the whole ethical argument gives rise to the question, is it ethical for the government to rely on revenues from the sale of a product that is harmful to a person's health?

One of the dilemmas pharmacists have always faced is, are we health professionals or are we retailers? In my opinion, pharmacists are both. We cannot lose sight of the fact that today's retail drugstore is made up of a front shop and a dispensary. In order for a pharmacist to be in a position to provide proper pharmaceutical care to his or her patients, both must be viable, unless the dispensary is located in a medical building where the pharmacy can survive on its own.

In the most recent Ontario College of Pharmacists newsletter, the college outlines the Regulated Health Professions Act, which was proclaimed in force effective January 1, 1994. I found it interesting that the act, which has jurisdiction over the dispensary only, recognizes the front shop as distinct from the professional area while at the same time the college is stating that in the case of tobacco it feels compelled to dictate which products are sold outside of the dispensary area.

As you can see, the issue is not black or white as to whether we are retailers or health professionals at the same time. Our own college can be inconsistent as to how it applies its regulations to drugstores, sometimes including the front shop and sometimes excluding it.

We must look at the retail drugstore as a whole to get the proper picture. Pharmaceutical care is the direction the pharmacist and the profession are taking with respect to the way the modern pharmacist should be practising. The concept places the patient as the focus, whereas the drug was the focus historically. This method of practice takes much more of the pharmacist's time and thus is more costly to the drugstore operator. Over the past few years we have seen our professional fees cut back, increasing pressures on our fees by third-party carriers and mail-order pharmacy, which is posing a new threat to our livelihood.

Removing tobacco from our stores while allowing other retailers to continue selling tobacco products is yet another blow to our bottom line, and I can only state that at some point there will just not be enough profit available to finance the extra services that pharmacists truly wish to provide to their patients under the pharmaceutical care model.

Within my practice I consult with long-term care

facility staff regarding the medications taken by the residents. I spend a great deal of my time in the facilities reviewing medication profiles for the purposes of simplifying patients' medication needs. Frequently this results in lowering the number of medications each resident takes.

This effort saves the provincial government valuable dollars while at the same time decreasing the revenue of the particular pharmacy location that is servicing the facility. Please allow me to emphasize that we are not paid a cent for these consulting services that we provide, beyond a professional fee.

I'm not going to propose to you that we need tobacco revenue to remain suppliers of long-term care, but as I mentioned before, continual erosion of the total store profits does put pressure on each of the components of our business to justify its existence.

In summary, please allow me to state again my opposition of section 4(2)8 of Bill 119, as in my opinion it will not result in the government's noble objective being fulfilled. At the same time it unfairly discriminates against one segment of the retail market and places undue financial hardship on a segment already hit by other pressures, including the provincial government, which recently cut our fees after a three-year freeze on them.

I thank you very much for your time and I will be glad to entertain any questions.

**The Chair:** Thank you. We're a little tight on time, but we'll try to work in a couple of questions.

**Mrs Haslam:** In July the pharmacists college asked for a phased-in removal and put an implementation strategy in place. Have you complied with this proposed voluntary phase-out in any way?

**Mr Gay:** I believe our president commented on behalf of the company on the corporation's objectives. What I can say is that we are in favour of voluntary cessation of smoking products and ultimately I think you will see pharmacies remove tobacco from their product mix, but I think we have to be given the time.

**Mrs Haslam:** That's another point. You mentioned your bottom line, which seems to be business-oriented and profit-oriented. We are here dealing with a health issue, and I think we have to keep that in context. You talk about allowing others to sell and not allowing pharmacies to sell, when in truth it's the pharmacists who come before us and say they're asking for a more level playing field. They're saying that unfortunately there are some who are not complying with the college's asking an implementation strategy. It's unfortunate that the government has to step in, but they are asking that the government step in to level the playing field for them, just as you are indicating that it would be a level playing field if nobody sold tobacco.

You're a pharmacist. Do you agree that smoking does have significant negative health effects on our population?

**Mr Gay:** Of course. I think I'd be foolish to say that I don't, and I have presented a Butting Out For Life program sponsored by Merrell Dow to over 150 pharmacists on five or six separate occasions. I agree we should

be involved in trying to counsel people on stopping smoking. But, going back to your issue on the bottom line, without a profit we won't be there to counsel people.

1050

**Mrs Haslam:** Do you feel that the financial benefit of tobacco sales should supersede the health goals in the future of a tobacco-free society?

**Mr Gay:** No, but I also feel that a person's right to purchase a legal product in a retail outlet shouldn't be superseded by the government as well.

**The Chair:** Time for one short final question.

**Mr McGuinity:** Not so much a question, Mr Chair, as a comment. I just wanted to thank Mr Gay for presenting a fair analysis of this issue. It would be nice if it was purely a legal issue or a moral issue or a business issue or a health issue. I think the fact of the matter is it's all of those.

If it was purely a health issue, we would have the nerve here today to ban smoking everywhere in this province immediately. But it's not. There are obviously other considerations. We squeeze about \$1 billion out of smoking Ontarians on an annual basis. We profit from that to some extent. Canada-wide we take about \$8 billion out of our smokers. It's not a simple issue. I think people do a disservice to the debate, an injustice, to treat it purely as a health issue or purely as a business issue. Thank you.

**The Chair:** Thank you very much for coming before the committee today.

SIMCOE-MATIC CANTEEN LTD.

**The Chair:** If I could then call on Simcoe-Matic Canteen, Mr Jim Dykes, president and owner. Mr Dykes, welcome to the committee. We have a copy of your submission so once you're settled, please go ahead.

**Mr Jim Dykes:** I bring you greetings from sunny Orillia this morning. I came down here under the mistaken impression that you have warm, sunny weather in Toronto all the time.

**The Chair:** Did you have warm, sunny weather in Orillia this morning?

**Mr Dykes:** Yes, we had a beautiful morning in Orillia. I trust it still is when I get back.

I'm here to speak to you regarding Bill 119, specifically section 7, as it relates to the vending industry and the vending of cigarette products.

A very quick background on our company is that we're an independent, family-owned company operating out of our head office in Orillia, servicing all of the small communities from Barrie to Huntsville to Collingwood and all points in between. We employ 16 people in those communities. Over half of our staff have in excess of 20 years' service to our company and to our many customers.

We provide a wide range of vending services, of which tobacco is just one. Tobacco does represent 25% of our annual turnover and it also represents 25% of our staffing. The assets that we purchased when we bought this business represent \$125,000 to our company and



we're a small company. That's a significant investment.

Our concerns are fairly brief. We're very sympathetic to the spirit and the intent of both provincial legislation and the federal guidelines specifically as they relate to the discouragement of young people from smoking.

We do not believe that a ban on cigarette vending machines, however, will have any effect on youth and smoking, nor will it have any effect on reducing overall cigarette consumption. Our locations and pricing are not typically available nor are they attractive to youths. Our vending machines are the most expensive source of cigarettes in the marketplace.

Vending machines account for three quarters of 1% of the cigarettes sold in Canada. Our vending machines do not offer kiddie packs. We have had in place for over three years now a proactive program that we did on our own accord to ensure to the very best of our ability that children don't have access to tobacco, nor are they allowed to purchase tobacco products from our machines.

Two years ago we sold our family home and with my partner borrowed a further \$500,000 to buy this business, a business that we understood to be a legal business and one that we pinned all of our future hopes and dreams on. A loss of 25% of our employees, which this legislation would immediately impact us by, 25% of sales and 25% of our assets would be a full-blown disaster and possibly a fatal blow to our growing company.

Specifically, our company would immediately be forced to lay off four people and incur the cost of retrieving and disposing of the \$125,000 worth of assets which are still sitting on my balance sheet. They cannot be used for any other purpose. While this is going on, we would be trying to keep the wolves from our door. I'm sure all of you can appreciate that banks don't get real excited about a business that loses 25% of its revenue virtually overnight.

In brief summary, we do not condone smoking. We do not think children should be allowed to buy cigarettes.

Section 7 of Bill 119 will not, in our opinion, accomplish the goals it is intended to. We operate our machines exclusively in adult environments, as a service to adults only. Without exception, I have canvassed every one of our customers and they appreciate our service and feel that if we do not offer the service we offer to them in an adult environment, the business will go entirely into the black market.

The reason our industry exists in adult environments is because people who operate those establishments cannot control the sale of cigarettes nor can they cover the inventory costs of carrying these products in their establishments.

We support the federal Tobacco Sales to Young Persons Act with regard to the sale of cigarettes through vending machines. The federal plan allows cigarette machines to be placed in bars, taverns or other similar beverage rooms; in other words, places where access is restricted to people who are 19 years of age or older.

We also happen to believe that the federal plan should be expanded to include all adult environments. I don't believe cigarette machines should go anywhere where

they cannot be controlled and that children could have access to them. I too have children and don't want them exposed to opportunities to purchase cigarettes. But I do believe that in a free society and with a legal product we should all have a right to exercise our rights.

If cigarette vendors are banned, cigarette sales will not cease. They will just be sourced elsewhere. We would like to ask, why then should our distribution channel, or one single distribution channel, be singled out and destroyed?

If our cries are not heard we would like to ask you for some things to help us through a transition. We would need time to depreciate those assets. We would need time to seek other revenue sources, and by seeking other revenue sources we can protect the jobs of the honest, hardworking, taxpaying Ontarians who built our company over the last 30 years and who will be innocent victims of this legislation.

On behalf of the Simcoe-Matic Canteen family, thank you for the opportunity to give our views. We urge you to ask our industry for help towards accomplishing your goals. We will help you, but please don't take away our dreams.

**The Chair:** Thank you.

**Mr Dykes:** If I could, on just one personal note, I've tried to remain unemotional but this is a very personal issue to my family, to the 16 employees who we help pay their mortgages every month. All of them will be watching this tonight on their television sets in communities from Collingwood to Midland to Orillia. These are real people with real children and dreams of their own.

When you make your decision about this legislation, it's not just a business. As Mr McGuinty pointed out, it's not just a health issue. There are real lives at stake. We'd appreciate if you'd think about that when you're making your decisions about changes to this legislation.

**Mr Jim Wilson:** Thank you, Mr Dykes. I think you make a very persuasive argument. The position of my party, the Ontario PC Party, has been to push the government for some sort of compensation and, secondly, a longer phase-out period. The only reason we've even taken that position is because I believe it's inevitable the government will pass this legislation. We're trying to be realistic about what we expect the government will do.

Having said all that, our preference would have been to simply leave vending machines in bars, along with the federal act, because I remember very well the federal discussions. I used to be EA to the Health minister there and it made perfect sense to me. In fact, a number of States have followed that route where, as long as the vending machine's near the actual bar so the bartender can give some supervision to it, it seems to be fine. It's my view that this government wanted to go further. They wanted a bigger headline than the federal act so they're going to ban you totally.

Having said that, you raise in your summary and recommendations on page 3—you talk about time, the necessary time to depreciate your assets etc. What type of a time frame would you require to do that?

**Mr Dykes:** For every operator, of course, it would be



different, depending on when they purchased their assets. Traditional depreciation period on an asset like that would be five years. I believe, though, that if we were given three years, that would give us the time that we could deploy our resources to go out and seek other businesses that we could put ourselves into, perhaps even seek out other products that we could retrofit these machines to serve.

To throw millions of pounds of junk metal into landfill sites or wherever they would go, to me seems an awful waste from an environmental point of view and from a practicality point of view. If we had three years, that would give us enough lead time to preserve the jobs in our company and allow us to get on with new businesses.

1100

**Mr Jim Wilson:** If the government were not to give you three years—the bill of course speaks to three months, which is a very, very short time frame—you mentioned that your physical asset in terms of cigarette vending machines is \$125,000?

**Mr Dykes:** That's a fact.

**Mr Jim Wilson:** Would that be the total compensation that you would require?

**Mr Dykes:** Exactly.

**Mrs Haslam:** I just love it when Mr Wilson is non-partisan. When we look at the federal legislation, and I agree we support the federal legislation—

**Mr Jim Wilson:** I take it as a compliment.

**Mrs Haslam:** No, it wasn't.

**Mr Jim Wilson:** I wouldn't expect it.

**Mrs Haslam:** Please don't.

**The Chair:** Order, please. Mrs Haslam, if you could just direct your question to the witness, please.

**Mrs Haslam:** The problem is that in the federal legislation and Ontario there is no age restriction to access, only in consumption. One of the concerns about this legislation was that it still left access to vending machines to young people. As a matter of fact, when we were in London yesterday they had a survey done in Lambton county that showed that out of 216 people who were questioned, 78 of those young people, which is more than 26% of those questioned, had access to vending machines. So it is a concern, it is a proven concern and it's something that when we're looking at this particular legislation and young people we, as legislators, have to be cognizant of.

Actually, my question was around the time lines. There was another organization of vending machine people who came in, who visited us. One of the questions I asked was, "Could you retool your machines?" I understand that in tobacco vending machines it's impossible or financially not conducive to retool the tobacco machines. I'd ask if you agree with that.

Also, they said three months was not enough time. They're going to be rushed just to take it out to comply with the federal legislation. They feel that if the provincial legislation comes in and extends it to those licensed premises, whether they're adult or not, because of where the machines are located and the access for young

people—they asked for an additional year; you asked for three. I wondered if you'd comment on that.

**Mr Dykes:** Sure. Let me take your points one at a time. I share all the concerns you have. I wasn't paying lipservice to the issue of children and smoking. We have no desire to ever sell a package of cigarettes to children.

I've never seen a single shred of evidence yet in all of the reports I've seen that indicates that children buy their cigarettes out of a vending machine. Typically, they're not available to them by their locations. Children are the ones with the least amount of money to spend. Therefore, we're their last choice to put their money into to get cigarettes and that suits us just fine. We carry very large stickers on there. We educate all of our customers who have our machines what the stickers mean on there, explaining the law as it relates to children buying cigarettes.

I have not yet ever seen, as recently as recent radio surveys done here in Toronto, any evidence that any children are using our particular machines for their source of cigarettes. But I still believe we should take every possible precaution to make sure that doesn't change in the future. Especially in light of possible tax cuts and all kinds of things, cigarettes could become more affordable out of machines.

**Mrs Haslam:** They're addictive. I think that's the problem when we look at it. When we do have a survey from a school that says they do have access, that's a concern for us.

**Mr Dykes:** I don't know the Toronto market, but I can take you to high schools in central Ontario where every day at lunch-hour the trunks are opened up and the black-market cigarettes are sold in open view to anyone who wants to drive in. They run drive-through services.

**Mrs Haslam:** I think we agree that enforcement is the problem.

**Mr Ron Eddy (Brant-Haldimand):** Totally ignored.

**Mr Dykes:** Totally ignored.

**Mrs Haslam:** Enforcement is one of the main things we're going to have to look at.

**Mr Dykes:** I agree. Getting to your other two points, the likelihood of retooling our equipment is remote. I don't rule it out, because I would like to seek out every possible opportunity, but that's one of the reasons that I've asked for a longer period of time. That's an awful lot of money I borrowed to buy those assets. I would like to depreciate them as much as possible. If I can get any other use out of them at all subsequent to that, that would help our cause and, of course, we can maintain the jobs.

The timing of the changeover would be a disaster to us, not just from the job-loss point of view but from a functional point of view. It's a big job moving vending machines around and we happen to be spread across all of central Ontario. Anything you could do to help us from any of the vantage points I have addressed this morning would be very much appreciated.

**The Chair:** Mr Dykes, we want to thank you for coming down from Orillia this morning and for your presentation and your personal views.

CATHY JAYNES  
SALEM KHAMIS

**The Chair:** If I could then call on the representatives of the York Region Public Health Department. I just draw to the attention of members that the parliamentary assistant and I are again proud to see representatives from York region before the committee. Welcome. Please go ahead. We have a copy of your submission.

**Ms Cathy Jaynes:** Thank you. My name is Cathy Jaynes and I work as a health educator at York region public health department. I have brought a co-presenter with me today, Mr Salem Khamis, who is the pharmacist-owner of Hillcroft Pharmacy. I'm going to talk first. His talk is more interesting and he's going to go last.

Just to talk about York region, we are primarily a residential community. The majority of our population is under 19 years of age, and certainly any legislation that's going to impact positively on the health of children and adolescents we are going to be very interested in. We are really pleased with the whole bill and we congratulate members of the government and members of the opposition on bringing the bill this far.

We're very happy with tightening control on sales to minors. Again, the majority of our population is under 19 years of age, so we don't want to see those youth have easy access to tobacco.

We are in favour of banning vending machines and we had to agree, from our point of view, with some of the youth who spoke this morning. As a former health counsellor at a high school, I used to know for a fact that many of my clients and many of the kids I saw when I was teaching birth control classes in grade 9, the same kids, were in the bars buying cigarettes from vending machines. The whole point is they are unmanned and anybody can put a coin in those machines. We are pleased to say that the city of Vaughan, which is in York region, has now banned tobacco vending machines.

Banning cigarettes by pharmacies is a crucial point. Tobacco should not in any way be construed as a therapeutic substance. It should not in any way be associated with health care or health care services. I know that people will say: "Well, they're just going to go across to the mini-mart or they're just going to go around the corner. Do you really think it's going to have an effect on consumption?"

In the short term that may be true but, as you know, tobacco use prevention is a long-term issue. We have to start educating the public that you can't go into a pharmacy and buy goods for your health and then see cigarettes there, because indirectly the public will see: "They're in pharmacies. Surely cigarettes can't be that bad." This links back to commercials in the 1950s where cigarettes were advertised as helping coughs etc. We have to start calling an issue an issue and stand behind it.

We did a random telephone survey to just 40 pharmacies. It was very small, just every third pharmacy in a municipal phone book. Thirty-nine per cent of our pharmacies do not sell tobacco products, and they reported many positive comments, as Mr Khamis will talk about. A further 40% supported withdrawal, and of the

percentage that still sold tobacco products, 15% were going to withdraw tobacco products in the near future.

Some of the pharmacies that were still selling cited different reasons for why they still had tobacco products, some of these being the parent companies. They could not voluntarily withdraw tobacco products without facing a legal action. There was resistance to having a legal substance legislated off the shelf, which we've heard again this morning. Some of the pharmacists talked about, "Well, that's fine, do that, but then let's call tobacco a controlled substance and sell it in outlets such as the LCBO," and they felt fine with that.

The packaging regulations: We are in favour of generic packaging and recommendations on this. We would further like to see a complete list of the ingredients on the tobacco package. Consumers have the right to know what's in the product they're consuming. If there's any room after that on the package, we would like some health warnings.

Prohibiting smoking in schools and on school properties: Again, we have differing policies in York region. The public board has one policy, the separate board has another. We were quite shocked in 1993 to find that there were some schools contemplating using school funds to build shelters on their properties for smokers. This was a staff-generated committee. We have of course responded to our concerns, talked to them about it, but comprehensive legislation would put an end to this.

Again, effective compliance strategies such as fines and inspection are very important.

#### 1110

What I would like to talk about are some amendments that we feel should be included in Bill 119. I work in policy analysis in healthy public policy and I receive calls from people in the workplace who live or work in York region and who are very concerned about working in environments with secondhand smoke.

In the last six months I've received 53 calls, which may sound like a small number, but these people are very afraid to talk. They won't give me their names, they won't give me their places, I can't call them back. I'm just getting these calls while I'm sitting in the office for the most part.

The majority of calls were people who had a workforce of less than 20, so we're talking about small businesses, with typically no management or union support for their concerns. In many cases the employers or managers themselves smoked. Again, they're very afraid to complain for fear of losing their jobs. A majority of these people stated that they had just been hired at this job for less than six months after being laid off somewhere else, so for them, keeping their present job was a priority to the exclusion of their physical wellbeing.

They complained of things like nausea and headaches and watery eyes. One caller described working in a small office area, four workers around her with desks who would chain-smoke from 9 o'clock in the morning till 5 o'clock in the evening. Their friends would come in and often smoke at the desks as well. Clients and customers



would come in. She would go home, take her clothes and hang them in the garage. She would actually feel physically ill.

Unfortunately there was no municipal support for the work site. There is of course the Ontario labour board. In calling the labour board she was told, "Yes, the inspector will come, but it could be weeks or months and we can't really tell you when it's going to be." Her solution was to try and find another job and, when she got the other job, go to her present employer and say, "I'd really like to stay here but I can't." People feel they have to have something to fall back on.

There have been more educated people than I who have been talking about the dangers of environmental tobacco smoke. Since people in the work site spend about 90% of their time indoors, we really have to protect them from high-hazard environments.

Smoking in restaurants: These should be designated as smoke-free spaces not only for the patrons, but also recognizing that restaurants are workplaces for many people in York region and Ontario. Recent literature talks about levels of ETS as being up to two times higher than in offices and one and a half times higher than for residences. If you are a non-smoker, you have more of a risk from going to your workplace from environmental tobacco smoke than you do from living with a smoker.

In bars it's horrendous. It's up to six times higher than offices and 4.5 times higher than living with a smoker. These are really hazardous environments. The literature also shows a 50% increase in lung cancer risk among foodservice workers, and this can in part be causally related to tobacco smoke exposure in the workplace. That's pretty shocking.

It seems like those working in public service, and that includes myself, are protected from smoky environments. Many municipal, federal and provincial buildings are legislated as smoke-free. Surely we're not saying that we protect the health of the core of our public workers more than we do our private sector.

Smoking in public places: I receive a lot of calls especially from seniors who would just dearly love to go to a bingo parlour and they really miss this, but because of predisposing health conditions or they're afraid of having an asthma attack while they're there, they can't go. We would really like to see some more comprehensive legislation for arcades, bowling alleys and bingo parlours.

We as the health units and our many community partners will pledge our full support for the provisions in Bill 119. We are currently distributing free bylaw signs to municipalities. We are working with municipalities to strengthen their smoking bylaws. Two municipalities are currently strengthening, and I'm proud to say in Georgina we are starting to enact a bylaw by looking at smoking in the restaurants. I've seen the legislation, the bylaw, and it looks pretty good.

In conclusion, I would just like to again congratulate government members and opposition members. It's an excellent piece of legislation. We are concerned that perhaps some opposition members may not support the

vending machine ban or sales in pharmacies. We would like to see government work together. This is an opportunity for the members of the provincial government to send a message to all municipalities, to send a message across that this legislation can have a positive impact.

I'd like to also make special mention of Larry O'Connor, who has given a lot of leadership in this. We thank you for it.

**Mr Salem Khamis:** I just want to present an alternative viewpoint. We are an independent pharmacy. We have been in operation since 1986. As a matter of policy, we decided not to sell tobacco from the onset. It did hurt us economically obviously, but I decided that, as a health professional, I could not justify selling tobacco for my customers.

It didn't make sense to me to be selling tobacco at the front of the shop, and at the back of the shop selling prescriptions for smoking addiction and trying to help people prevent addiction to smoking. So as a matter of policy, we decided in 1986 not to sell tobacco. We've been in operation for eight years. We have survived, fortunately. Maybe we would have made a little bit more money had we been selling tobacco, but as a health professional I feel proud of myself in having taken a decision before it was legislated.

It's unfortunate that we have to come to a stage where we have to legislate tobacco in pharmacies. I would have preferred voluntary cessation. It seems to me it has not worked. The OCP has been trying for years; the Canadian Pharmaceutical Association has been trying for years. You've heard a lot of presentations from big stores that say how desperately they need the revenue from tobacco. I just want to let you know that there are two viewpoints. I'm an independent pharmacist. I don't have any axes to grind and whatever I do in my store affects me directly.

Another point that I wanted to bring across was that our customers have been very happy with our decision. We've had a lot of customer loyalty because of the fact that we don't sell tobacco. I feel we should bring pharmacies into a position where, when you walk into a pharmacy, you know you're in a health field.

When you walk into a hospital or a doctor's office, you don't expect to see vending machines for tobacco. The same way, when you walk into a pharmacy, you should not expect to see tobacco. Unfortunately, it has to be legislated. I don't agree with the government legislating what a drugstore can or cannot sell, but I feel in this issue we're on the right track. That's all I wanted to say.

**The Chair:** Thank you. We have a few minutes for questions.

**Mr McGuinty:** Thank you both for your presentation. Something I wanted to mention is that I was surprised myself to learn yesterday, when we had an owner from Shoppers Drug Mart, I guess a franchisee, that he was not required to sell tobacco products within his store; rather that was a matter of his choice. I thought I should share that with you.

The other thing, Ms Jaynes, is you've raised something which a lot of people feel. They come here to see us and



they have a sincere desire to see us do whatever we can to curtail smoking. That's a very legitimate position to take. But just so that you can understand and anybody who might be watching us today on TV can understand, in opposition our obligation is to ensure that all perspectives are brought forward. It is rarely our obligation to join hands with the government and to not bring forward those positions which might not otherwise be heard.

I think one of the serious difficulties with the legislation is connected with the ban of sales in pharmacies, for a variety of reasons, one of which is that it will not reduce smoking overall, and it strikes me as a patent unfairness. It would be fairer, for me, to ban it everywhere. It would be fairer to restrict it to an LCBO equivalent, for instance. Anyway, I just wanted to leave you with that. If you want to comment, please do.

**Ms Jaynes:** Again, I agree that in the short term it may not reduce consumption. The point I was trying to make was that we are trying to change people's health attitudes in tobacco use prevention. In changing health attitudes, I think it's just vital that we don't associate tobacco with health care products and services. That's the first step. There are no quick fixes, I agree with you, and there may not be small or immediate effects on consumption, but I feel this is the way to go for the long term.

1120

**Mr O'Connor:** Thank you for your presentation and your kind words. Looking at page 3 on your brief, you talk about your survey. I appreciate the comments. In noting those who had not voluntarily removed them, you cited the first one as saying selling the products as a policy of their head office. Of course they had some concerns there. I wondered if you'd like to add to that comment.

**Ms Jaynes:** It was just a telephone survey. I think it was Big V and Shoppers Drug Mart. Please excuse me if I'm wrong, but I believe that those were the pharmacies. They were saying, "Well, the pharmacist-owner said, 'Yes, I would be pleased to, I would love to,' but this is policy." Now, we did not go into whether she wanted to go into an independent pharmacy and we did not explore the legal issue, but these were the comments made to us.

**Mr O'Connor:** So there was a real fear that—

**Ms Jaynes:** There was a fear. She said, "This is a policy of our head office, and I cannot voluntarily withdraw these products."

**The Chair:** Thank you both again for coming before the committee. We appreciate it.

CANADIAN CANCER SOCIETY,

ONTARIO GEORGIAN LAKELANDS REGION

**The Chair:** I call on the representative from the Canadian Cancer Society, Ontario Georgian Lakelands region. It's Ms Gretta Gill. Welcome to the committee. We have a copy of your submission. Please go ahead.

**Ms Gretta Gill:** Thank you. Mr Chair, honourable members of the committee on social development, the Canadian Cancer Society provides its services through nine regions across the province. You will have heard in our initial submission about the mission of the society and about its volunteer base. I am one of those volun-

teers, working in the Georgian Lakelands region as one of more than 1,700 volunteers there. I am president of the region, overseeing its numerous programs and committees.

The region encompasses the counties of Bruce, Grey, Simcoe and the Muskoka area. In these counties, the society estimates that 6,400 people died of tobacco-related disease from 1976 to 1985. These were unnecessary deaths.

To help eradicate cancer, we believe that the reduction of smoking as an addiction is a vital step. We are pleased to see Bill 119 as part of the government's tobacco strategy and, in particular, as supporting the strategy's intent to make all schools, public places and workplaces smoke-free by 1995 and, throughout the 1990s, to reduce the percentages of the population who smoke. We will see a payback in the improved health of the population in the years to come.

The Georgian Lakelands region subscribes to the views presented in the Ontario division's brief presented on February 1. We're here to present some additional factual information and our reasons for believing in the need for the legislation. We are also here to comment on relevant experience.

As a health agency, we are concerned about saving people's lives and improving the conditions of those lives. Bill 119 is important to help reduce the considerable number of illnesses and deaths caused by tobacco's impact on the human body. While our mandate is to eradicate cancer and to support those affected by cancer, we are part of the network of health agencies with a shared vision of an Ontario society unburdened by the consequences of tobacco-related diseases.

As a volunteer with the society, I believe this legislation is crucial. As a citizen and a member of the community, I also believe this.

You have already been given a lot of facts. I've read these too and I'd just like to reiterate some of the ones I find particularly disturbing.

Tobacco is a major contributor to death in Canada. One Health and Welfare study estimated that for every 100 smokers now 15 years of age, 36 will die of tobacco-related diseases before age 70. Other studies suggest the number is higher, about 50%. This represents eight times as many deaths as those due to car accidents, suicide, murder, AIDS and drug abuse together.

The average age of beginning smoking has dropped from 16 to 12. In a 1986 survey, 88% of young people who smoked had considered quitting; 72% had already tried but been unsuccessful.

Some consider tobacco to be a gateway drug leading to abuse of other drugs.

In 1989, regular smokers aged 12 to 19 consumed some 576,056 cigarettes a day, or 12 each.

As a municipal councillor, I can provide a personal perspective on the tobacco-related activities in the town of Collingwood. We have a town bylaw prohibiting smoking in public places in the town. In addition, some of our retailers have voluntarily deemed their retail stores to be non-smoking.

I'm also a member of the board of directors for our hospital board at the Collingwood General and Marine Hospital, and it too is a smoke-free facility.

We endorse the Ontario division submission to this committee and fully support all the suggested amendments and additions contained therein. We believe that the following essential components should remain:

Designated age of 19 for purchasers of tobacco products: This will be consistent with the legal age for purchasing alcohol and will allow the use of the same identification. Hopefully, an increase in the legal age for purchase will postpone and in fact avoid the decision by young people to smoke.

In talking with a local pharmacist in Collingwood, he felt that tobacco purchases should be only at LCBOs and at Brewers Retail. I happened to hear, just as I came in, in the last submission they were mentioning that as well. That's what his thought was and that it would not affect his business or his pharmacy not to have cigarettes.

Ban on vending machines and the sale in prescribed places: These provisions will make it more difficult for young people under 19 to buy cigarettes and impossible for anyone to purchase them in health care institutions.

Prohibition of the sale of tobacco products in pharmacies: It's important that pharmacies be recognized as health care establishments, not just ordinary retail stores, and that they not sell items which destroy people's health.

Restrictions on places where smoking is permitted: It's important that smoking be disallowed in public places, school properties, day nurseries, stores and their grounds. Some of the smokers we assist tell us that restrictions on smoking in these places and in their workplaces have helped them to stop smoking.

In particular, it's vital that smoking not be permitted on school grounds. If it's prohibited, children will not see teachers, who tend to be children's role models, and teenagers who already smoke will find it more difficult to smoke during the day. In our area, Simcoe county, the schools already prohibit smoking on the school grounds.

We would like to see plain packaging adopted as well as warnings in clear, simple English.

Strong penalties for non-compliance: Enforcement must accompany progressive laws.

We endorse the strengthening of the legislation recommended as follows:

The legislation must place a ban on the sale of chewing tobacco, again often used by children's role models, baseball players.

The legislation must prohibit the sale of kiddie packs.

As mentioned above, the legislation must broaden section 9 regarding places where smoking is prohibited to include the grounds of the places cited.

The legislation must add a section to ensure that advertising and promotion of tobacco products is prohibited.

The legislation must provide for licensing of tobacco retailers.

We must collectively focus on the objective of improv-

ing public health. If there is one value we should all hold in common, it is the value of human life. We should do everything possible not only to preserve life but also to ensure a high quality of health for everyone. There may well be no other piece of legislation you are able to influence which has had such direct known benefit to the people in this province.

I congratulate you for your stand in promoting this type of legislation.

**Mr Jim Wilson:** Gretta, thank you very much for making your way down from Collingwood this morning and appearing before our committee. I understand the weather wasn't so great.

**Ms Gill:** Actually, it was lovely all the way until I got to Toronto. The sun was shining back home and everything was great.

1130

**Mr Jim Wilson:** You know, Gretta, I've always believed that.

Thank you for your presentation. I think it's one of the most succinct and direct that we've had. I would agree with about 98% of it. We have a bit of a disagreement with respect to pharmacies. My party has taken the position that we see it as a freedom-of-business issue and that we do see pharmacies as a section of the retail sector out there. None the less, we agree with just about everything else in the legislation, and your suggestions for tightening up the legislation are quite good.

I want to go one further. It's an idea I've been floating around for a couple of weeks. It seems to me that the current model doesn't work very well, that we have a punitive system on retailers. We fine retailers but we put no responsibility on the young person currently under the age of 18. They can go and buy cigarettes. If one retailer won't sell it to them, then they just go down the street to another. They just keep trying or they buy them out of the trunks of cars.

We've been floating around the idea that perhaps, like alcohol, we should make the consumption and possession of cigarettes under the age of 19 illegal, with a phase-in period, recognizing that there are a number of young people today who are addicted. What are your thoughts on that?

**Ms Gill:** It sounds like a great idea, the problem being enforcement of course. I do know that the property owners around the schools where there isn't any smoking on the school property have mentioned to me that they don't appreciate the cigarette butts they find on their grass, and so on. It's because they're not allowed to smoke; there isn't a designated area for them to smoke any longer. I'm sure they would be in favour of community service or something of that nature as a penalty for students who are smoking under the age of 19.

**Mr Jim Wilson:** We asked some young people this morning who are smokers who appeared before our committee, which is the first time, I think, we've had a string of admitted smokers appear before the committee, and generally they didn't feel it would matter one way or the other.

We couldn't seem to get out of them how in the world



to get them either to stop or not take up the habit. They basically said it's trial and error. Some people will smoke and some people won't, and there's nothing you can do about it. In fact, if you tell them they can't, it's just more of an enticement to start smoking. There was one young gentleman, though, who agreed that anything you could do to crack down—and he did agree that young people should take some responsibility.

It strikes me when I drive by Collingwood Collegiate and there's the Becker store at the corner that, even though they can't smoke on the grounds of Collingwood Collegiate, it doesn't matter. A few yards away they huddle around the Becker store.

**Ms Gill:** The property behind Becker is where the lady was complaining about the butts to me.

**Mr Jim Wilson:** I feel sorry for the Becker store owner because suddenly employers in this province have become cradle-to-grave caretakers of the people of this province. I appreciate your comments with respect to sharing the responsibility for the problem.

**Ms Gill:** I work in an elementary school as well in Collingwood and we try to educate the grade 6, 7 and 8 students about the dangers of smoking and how they'll be addicted for life, and so on. We have great posters about how your clothes smell and it's like kissing an ashtray, and all of the rest of it. You still end up with a couple of grade 8s who try to start smoking as, I guess, a rebellion against parents and so on.

**Mrs Haslam:** One of your recommendations was providing for licensing of tobacco retailers. Why do you feel that would be more effective than what is already proposed as a ticketing model within the legislation?

**Ms Gill:** To have them licensed, they will hopefully be more diligent at checking ages of 19 years of age, showing an age of majority card or a driver's licence, or something. I feel, as Mr Wilson has mentioned, that they will continue to go on. If one place won't sell them cigarettes, then others will. If it's licensed and legislated properly and there are penalties for non-compliance, then I'm sure that would assist.

**Mrs Haslam:** Are you aware of the model that I'm talking about that's being proposed, where you're ticketed and on a second offence you lose the right to sell or have tobacco?

**Ms Gill:** Yes, I am.

**Mrs Haslam:** Okay. That's fine. Thank you.

**The Chair:** Thank you again very much for coming down and making a presentation to the committee.

#### ONTARIO FEDERATION OF HOME AND SCHOOL ASSOCIATIONS

**Mrs Norma McGuire:** Mr Chairman, I'd like to introduce us. On my right is Ruth Woodcock, the first executive vice-president of the Ontario Federation of Home and School Associations, from Etobicoke. On my left is Betty Turner, the president of the Ontario Federation of Home and School Associations, from Windsor. I am Norma McGuire and I'm the immediate past president. I'm from Etobicoke as well.

First of all, I'd like to really give you some praise for

having seen the bill get this far. I think it's great that we have been able to do that. The minister has put a lot of effort into this and I know the ministry staff have also put forth great efforts. I really appreciate what you're doing for the young people of Ontario.

I'm not going to go through the paper you have in front of you in any way, shape or form. The first page is an overview, and I would like to highlight a couple of things from that. We are over 18,000 identifiable volunteer parents in the elementary and secondary public school system across the province. The back page shows our board of directors' list so that you know that we do represent a very broad spectrum of this province.

We were formed in 1916 in Ontario to put forth an advocacy role on behalf of children and youth. In 1985, the Canadian Home and School and Parent-Teacher Federation was formed for health issue reasons.

The mission statement you will see is on page 2 and in there is our motto, "The best for each student." Following that are the belief statements, and I don't plan to read those to you. We want the best for a child or a youth in every aspect of their life.

We're typical parents. We're typical citizens of this province. We don't come with a wealth of research background or that type of thing. We aren't going to give you a lot of data. You've received that from a lot of other people, so we're going to go on to other things rather than repeat.

We are advocates for youth. We're concerned about their health and wellbeing now and into their adult years as well. Yes, we do have a vested interest in this hearing: it is the health of our children. No one's paying us to be here either. We cared enough to come on our own. We spent our time, our energies and our own dollars to be here. We definitely don't have a vested interest in that way.

We support the OCAT submission that you heard on February 1 and the Council for a Tobacco-Free Ontario presentation that you will hear later this afternoon. I don't want to go into the details of those.

As early as 1965 parents across this country were asking for legislation about tobacco. We asked at that time for the curtailment of cigarette advertising and for promotion of anti-tobacco campaigns. Almost 30 years ago we were asking for this legislation. We're still waiting. Even last year at our annual meeting in April we asked again for zero tolerance towards smoking in the buildings and on the property of all Ontario elementary and secondary public schools. It has been a long wait and we're still in there trying to get this to happen.

When used as intended, tobacco is lethal, addictive and illegal for those under 18, and you know that. It's legal, but it's lethal and addictive for those over 18. We're asking you to raise the age to 19, to prevent the onset of tobacco use for as long as possible.

Please stand also on the tobacco tax. I understand something was to have happened with that this morning. I missed it. I ask you not to follow the example of the federal government or the government of Quebec. Be strong.



We ask you to eliminate kiddie packs. It's easy for young people to buy a pack of five cigarettes. Eliminate the sale of individual cigarettes. They're easier to get than ever. A minimum pack size of 20 is the norm and should stay that way.

**1140**

We also would like you to remove the purchase opportunities for buying tobacco. License the retailers. I heard someone say strict penalties. I'm asking for severe penalties for those who sell to underaged people. The proof-of-age card with a picture is successful in the alcohol focus, and I would like to see that happen with the tobacco issue as well.

We heard a few minutes ago about smokeless tobacco, and through our brief you will read our opinion about the issue of spitting tobacco.

It's our duty, but it's also your duty, to ensure that access is limited, onset is delayed and use is prevented. Parents want long, healthy, tobacco-disease-free lives for their children. There's nothing worse than seeing a parent struggling with the death of a child, whatever the reason.

We ask you to continue to support young people. Regardless of your party affiliation, our children's lives depend on you and on the passing of Bill 119. Please encourage your colleagues to vote with you in favour of Bill 119.

**Mrs Haslam:** On one of your pages you talk about the number of mixed messages. It's a concern to us, looking at the pharmacies in particular and the fact that they are in the health care profession. Pharmacists are health care professionals governed by a body, a college of pharmacists. How important are mixed messages to young people?

**Mrs McGuire:** They are very important. I think I could pass that question on to Ruth, who sits on the Alliance for Children and Television, about mixed messages, media literacy and that type of thing.

**Mrs Ruth Woodcock:** I think basically the only thing I want to say is that as far as it goes with television, children are a captive audience when it comes to television, and you see them going from one place to the next. Violent acts are increasing in schools. This is off cigarettes, but I think it has a bearing. It's increasing all over the place because of what the children are seeing on television, and I think smoking goes the same way. They're influenced greatly.

**Mrs Dianne Cunningham (London North):** You're not alone in your presentation, but I'd like to congratulate you on your stamina. Thirty years is a long time and some of us have been there with you.

These kinds of things happen to us, if you know what I mean. We get ourselves elected to do some of these things too. It's long overdue and it's been a goal I think of parents that we see this strict legislation. I can tell you that we're certainly going to be supporting this, but we'd like to see it strengthened.

We think the regulations or the legislation itself must include the licensing of the retail outlets. You've already stated that. We'd like your opinion, because we've heard from two other presenters, a public health unit and the

cancer society, with regard to banning it from school properties.

With that, I'd like you to think about a very strong position that one of the health units from Windsor took yesterday. They thought that the responsibility should be on the young people themselves, and if in fact there were fines with regard to drinking underage, there ought to be with smoking. So they were talking about some kind of sanctions against young people.

I personally would agree with that. I think we've tried the education route for 30 years and I've become quite cynical about trying any harder. These young people are on the properties of other private citizens, as we heard in Collingwood today, and smoking next door to the schools. That's one of the problems the school boards have, although I like your strong position.

I wondered what you would say about going further with young people and their responsibility and any suggestions you might have for the committee with regard to school property, because we know what a challenge that will be if it appears in the legislation, but I think some of us are seriously considering it.

**Mrs McGuire:** I guess at the school where my children attended, there was the typical cancer corner—and that's what they called it in elementary school, "cancer corner." They knew, but it didn't prevent them going on someone else's property. I don't know how one does prevent that, other than constantly complaining to the students. Then they become very negative towards that person, and who knows what might happen.

I think you would need to have an age restriction at which you start it. To expect a 10-year-old to pay a fine would be difficult. It's going to be parents who would pay that fine. There are children who do have part-time jobs as they get older and that might be a deterrent if they knew they could be fined. Does that answer your question sufficiently?

**Mrs Cunningham:** Yes. I think you have taken a strong position, and I guess what we're looking for in the committee is that kind of support, because we know how contentious it is to say, "You can't smoke on school property," and then have you smoking on all the neighbours' properties. So maybe there ought to be some penalty involved with this. The enforcement would be something that I think young people would think about.

**Mrs McGuire:** The penalty may not be monetary; it may be doing some community work, which may be better.

**Mrs Cunningham:** I think that was mentioned by the cancer society earlier, that it might be a good idea.

**Mr McGuire:** I too am concerned about a mixed message. My colleague Ms Haslam raised this issue of a mixed message with respect to pharmacies and, as you know, that's subject to considerable debate here. But I'm concerned about another mixed message we're still going to be sending at the end of the day here after we pass Bill 119, which, by the way, is by and large a very good bill.

**Mrs McGuire:** Definitely.

**Mr McGuire:** That is, I'm a kid, I'm 13 let's say.

Now, the message I'm getting is: "When I'm 19, then I can get at those darned cigarettes, then I can make myself sick. So all I've got to do is wait, and then when I'm an adult I can do stupid kinds of things." I think that's still a mixed message.

What I'm hoping is that some day a presenter will come before us and say: "Listen, we've got a plan. It's a long-term plan to phase tobacco out of this province." Maybe something like, first, we're going to restrict the sale to the equivalent of an LCBO, and then later on you can't get the darned things without a prescription, something along those lines. But I just am frustrated that we're nibbling away constantly at the edges and we're still sending out a mixed message, we're still endorsing it implicitly in the province. It's a legal product. What do you think?

**Mrs McGuire:** First of all, the later a person starts to smoke, the more likely they are not to, and I think that will continue regardless. I don't see it as being, "I'm going to be 19 and I can do it." I think if they know, if they've had that education, they've had that pressure, there won't be as much peer pressure from their friends to smoke. They will be able at that time to see some of their parents, their relatives who have smoked and are then suffering in some way, if they have not been denied that relative or a friend. I think it will take them some time to realize, but by the time they're 19, they should be able to make the proper decisions.

**Mrs Woodcock:** I'd just like to add that at that time they've also probably had the further advantage of more education on the disadvantages and the problems with smoking and tobacco because they've had a chance to finish their education.

**The Chair:** I want to thank you on behalf of all the members of the committee for coming before us this morning. We appreciate it.

*The committee recessed from 1150 to 1331.*

**The Chair:** Good afternoon. We begin our afternoon hearings in the standing committee on social development. We are reviewing Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others.

Before calling the first witness, members of the committee, I'd just like to note that we've received two documents from research: One is the summary of recommendations to date in the hearings we've had, as well as a fairly copious compendium of recent press clippings, but this issue being what it is, I suspect the clippings will continue to grow. Members have a copy for their information.

PETERBOROUGH COUNTY-CITY HEALTH UNIT

**The Chair:** With that, we will begin our afternoon's hearings and I would invite the representative from the Peterborough County-City Health Unit. We welcome you. I hope your drive down was not too difficult.

**Mrs Christine Finlan:** I took the bus.

**The Chair:** I guess I should say I hope it won't be worse going home. It doesn't look too nice out there. But in any event, we welcome you to the committee. If you'd please identify yourself, we have a copy of your sub-

mission, so please go ahead.

**Mrs Finlan:** I am here today representing the Peterborough County-City Health Unit and the Coalition for a Tobacco-Free Peterborough. I'm Christine Finlan, a health promoter with the health unit's tobacco use prevention program.

We would like to take this opportunity first off to commend the Health minister and the NDP government for bringing forth this legislation. Bill 119 is an excellent step towards comprehensive tobacco legislation in our province.

In Peterborough we are very concerned about the effects of tobacco use on our population. We see more than 200 deaths a year attributable to tobacco use and that's clearly unacceptable. We cannot continue to tolerate the human and financial costs.

Clearly the focus of any tobacco control legislation needs to be on your youth. We need to ensure that they do not start smoking. Once children have been lured into that tobacco market, they are trapped in a lifetime of addiction, and sadly, all too often, in a lifetime that's shortened.

Effective public health measures are required to limit both the access and exposure to tobacco use. Licensing of retailers must be part of Bill 119. Most minors purchase their tobacco in retail stores, and we know that enforcing restrictions on the sales to minors results in reduced smoking rates among youth. We know what works; let's do it.

Currently the legislation is confusing and does not provide an effective deterrent for retailers not to sell tobacco to children. Store owners have been left virtually to interpret the law on their own. A recent survey in Peterborough of our grade 9 students indicated that half of those underage smokers were able to buy their own cigarettes and only 20% were ever asked for identification.

In Peterborough an education campaign to inform retailers of their moral and legal obligations not to sell to minors revealed that retailers basically wanted to do the right thing but they were unsure about what the law required of them. In one particularly interesting example a gentleman had saved all of the notes he had ever received from parents stating that it was okay for their kids to buy cigarettes. He put them all in a plastic shopping bag and toted them out very proudly, yet the fact remained that he was still selling cigarettes to underage children.

Cleaning up the current requirements is a positive first step, but the law needs to be clear and it has to be enforced. The threat of losing a licence to sell tobacco would facilitate that enforcement.

We need to ensure that we do not produce another generation of tobacco users, but we also have a responsibility to protect those who cannot protect themselves from exposure to secondhand smoke. Unborn children, children and seniors are particularly vulnerable to the effects of environmental tobacco smoke, or ETS. They're powerless to control their environment or to leave it.

There is no debate about the health hazards associated



with exposure to ETS. We've all heard it. The US Environmental Protection Agency has classified it as a group A carcinogen, meaning it causes cancer in humans. Any level, then, of exposure is clearly unacceptable and it's irresponsible.

We recommend to the committee that Bill 119 then be amended to prohibit smoking in all public places. It stands to reason that if a substance is hazardous in one area, it's a hazard in another.

Exposure to ETS in public places has an immediate effect on the health of our population but it also affects the smoking rates of our youth. Our children do not acquire their attitudes and beliefs in a vacuum. Adolescents have a need to belong and they are influenced by the overall rules and values of our society. By eliminating smoking in public places we send a clear message to our youth that smoking is not a socially acceptable behaviour.

Right now, we're sending very confusing messages to our youth. On one hand, they hear a lot of information about all the health hazards of smoking, both to the smoker and to those around them. Yet there appears to be a reluctance to take the necessary steps to remedy the situation. Children can be exposed to ETS in all public places, and by eliminating smoking in all public places, we would be helping to protect the health of our more valuable resource, our children.

In Peterborough we've been doing a lot of work in this area in particular and we've come a long way. We've had a bylaw in existence since 1988 and a total ban on smoking in public places has been introduced. A number of places have gone smoke-free on their own: Our shopping malls, hospitals, schools, our community college, memorial arena, municipal buildings, some restaurants and most recently a doughnut shop are all smoke-free.

Despite how far we've come, we can't go any further without your help. There are 17 different municipalities within the county, each with its own guidelines and regulations. Achieving a level playing field, you can imagine, is almost impossible. Municipalities are reluctant to take responsibility for controlling a substance that remains legal in Ontario. Though there's virtually no debate over the health issue, there is a feeling that this problem is of a greater magnitude. It's not unique to Peterborough; all of Ontario is affected by tobacco use.

At the health unit we receive a great many calls from people in the community who are concerned about exposure to secondhand smoke and they want to know what to do. The problem is that, sadly, all too often the current laws are being upheld; it's just they're not sufficient to control exposure. We urge you to remain committed to health promotion and illness prevention in order to achieve a higher level of wellbeing in our province.

In closing, I would like to address the committee as a mother of two, soon to be three, and as a health care professional. Let's not forget what the issue is really about: It's about the lives that are at stake. It's not about the taxes and jobs and freedom of choice or enterprise; it's about the lives. I often wonder how many tax dollars

it takes to equal one human life.

I urge you to act responsibly in the face of the evidence. Clearly the lives of the people of Ontario depend on you for today and tomorrow. Let's continue to work together and make tobacco use something our children will learn about only in their history lessons. Thank you.

**1340**

**Mr McGuinty:** You, like many other presenters, have raised this idea of putting into place a licensing system, and the government I gather had heard this prior to drafting the bill and decided not to go ahead with it.

I just had a question. I look at the fines that the government has come up with in Bill 119 and they seem to me to be pretty darned stiff. If you sell to somebody who's under 19 the maximum fine if the defendant's an individual is \$50,000, and then there's a prohibition period I think of six months. That seems to me pretty tough. If I'm somebody out there operating a small store, that's going to scare me and hopefully it will have the desired effect, which is to ensure that I won't sell and I'll be very, very careful.

I'm just wondering why you don't think that will be effective, and of course the thing that we have to balance on the other side of this is to impose a further burden on our small business operators in the province with government paperwork.

**Mrs Finlan:** I think the key to anything that's proposed is the enforcement issue. We could have a very stiff fine, but unless there's a real threat of being caught, it doesn't have any teeth to it, does it?

I think any enforcement of the act has to begin with a knowledge of who the retailers are to begin with. That's a clear place to start. I think by a licensing system that means that the retailers have a bit of a vested interest as well in upholding the law. I think just having a stiff fine on its own is not enough. There has to be clearly some enforcement of that, and I think that licensing would help to provide some of that.

**Mr O'Connor:** Thank you for your presentation. I just listened with interest to what you've said here and have to agree with my colleague Mr McGuinty here. I thought that it was pretty clear: "No person shall sell or give tobacco to a person who is less than 19 years old."

It goes on further in the next subsection and we've heard, "It is a defence to a charge under this section that the defendant believed the person receiving the tobacco to be at least 19 years old, because the person produced a prescribed form of identification." So we're asking for identification. Now we've asked that that be changed so that it includes a picture on the identification so that we're not leaving it kind of wishy-washy out there.

I think as well that the fines and the penalties are pretty stiff, as my colleague has pointed out. Would you go so far then as to recommend that not only do we include what we've laid out in the statutory measures but if, for example, you've been caught once, twice or earlier convictions, would you go so far then to say that those prior convictions will be convictions not only under this act but under federal acts as well? Then when we talk about being charged, the person is not just being charged



under this act but also being charged on tobacco-related charges under federal legislation.

**Mrs Finlan:** I'd have to say honestly that I haven't thought necessarily about provincial versus federal charges that way. Again, I think the key is the enforcement of whatever is put in place, that there has to be a true threat to the retailers in order for whatever happens to be put in place to work.

**Mr O'Connor:** I guess then a key would be that not only at the hearings do we have a chance to talk about it and the public is being made aware of it, but also follow up public awareness by the government to let retailers know that this act is in force.

**Mrs Finlan:** I think awareness and again enforcement. There has to be enforcement.

**The Chair:** Thank you very much for coming before the committee today. We wish you all the best.

LESLIE BRADEN

**The Chair:** If I could then call on Leslie Braden, Pharma Plus Drugmart, Barrie. Ms Braden, help yourself to some water and welcome to the committee. Please go ahead.

**Ms Leslie Braden:** Members of the committee, I am Leslie Braden, a pharmacist and a pharmacy manager for a Pharma Plus Drugmart, which is a community pharmacy in the Bayfield Mall in Barrie, Ontario.

I would like the members of this committee to consider the impact and the implications of Bill 119 in my local marketplace. As a health care professional I support the intent of Bill 119 to further restrict the sale of tobacco to minors by increasing the legal age for tobacco purchase.

However, I cannot support section 4(2)8 of this bill, which would prohibit the sale of tobacco in pharmacies. This discriminatory legislation would not serve the goal of protecting our youth and is an abhorrent restriction of freedom in the marketplace to sell a legal substance.

As you may know, the 61,000-and-some residents of Barrie have been devastated over the last several years by the downsizing and closure of major employers like General Tire, Tambrands and Hill Refrigeration.

The pharmacy in which I work is 7,000 square feet of retail space located in a residential mall. We are open every day of the year, except for Christmas and New Year's Day. We are conveniently accessible to our patients evenings and Sundays. The store employs nine full-time and 10 part-time staff within our various departments, including our dispensary, our over-the-counter medication department, cosmetics, infant care, confection, tobacco and sundry departments.

Under the same roof, within the same shopping mall, are four other general retail stores which sell tobacco. Traditionally in a drug store located in a mall the selling of a blend of merchandise, sometimes referred to as "front store," has subsidized supervision of extended hours of pharmaceutical care services.

This subsidization has become increasingly important as the rising unemployment in our community has swollen the numbers of general welfare and family benefit recipients. As those utilizing the Ontario drug

benefit program have increased, profitability in the dispensing area has dropped drastically. Due to the restrictions in the number of items reimbursed, the freezing of the dispensing fee and the social contract clawback, I have seen my dispensary's gross margin drop by 10%. This is not healthy in business.

Tobacco in 1993 represented 23% of the front-store sales and 15% of the total sales for the store. In terms of total dollars of sales generated, tobacco was the third-largest category after prescriptions and over-the-counter medications. Tobacco sales in 1993 contributed 23% of the dollars to total store net profit, or to the bottom line. If tobacco was removed from the store, we would have to cut our wage dollars proportionately. Considering 1993 figures, this would mean two full-time positions would be cut or reclassified to part-time and additional part-time hours would be reduced.

These figures do not include the loss of revenue to my store due to the loss of companion sales should the legislation be passed. Those additional items now sold at the time of the tobacco sale have been estimated by the Coopers and Lybrand consulting group to be 25 cents to 37.5 cents of additional sales on every dollar of tobacco sales, so we stand to lose more. Those companion losses could result in further staff cuts in my store.

Across the province Coopers and Lybrand concluded that banning the sale of tobacco from pharmacies could result in 133 potential pharmacy closures and the loss of 700 full-time and up to 2,000 part-time jobs. This is no small matter. When there are already other tobacco vendors under the same roof in my mall, do you really suppose there will be any less cigarettes sold because their sale is banned in my pharmacy? A vendor could even set up a tobacco kiosk less than 10 feet from the entrance of my pharmacy to take advantage of the recently diverted traffic.

I believe Bill 119 will not change the volume of tobacco sales, but only their location. Bill 119 will unfairly discriminate against pharmacies by prohibiting the sale of a legal product from a closely controlled environment. Those sales will be driven to other retail outlets and to the contraband tobacco market. The intent of Bill 119 to decrease sales of tobacco to young people is worthwhile, but shifting distribution from pharmacies and leaving its sale in other retail outlets will only be creating an unfair playing field and will not have an impact on the number of cigarettes smoked by minors.

The Lindquist Avey study on tobacco distribution found that retail pharmacies are the most diligent in enforcing the ban of tobacco sale to minors. Removing tobacco sales from pharmacies will increase sales in other retail outlets where the same study says the laws are much less stringently enforced. The fewer number of legal outlets for tobacco, the more likely smokers will be to participate in the contraband tobacco market, an arena where the government has then absolutely no control.

1350

The size, location, rent and staffing of my pharmacy have been predicated on the existing sales mix, which includes tobacco. I'm not sure if you're aware that many

drugstores, particularly in mall locations, have their rents tied up in long-term leases with a percentage rent component. The percentage of tobacco sales paid as rent is about one quarter of our other products. So the bottom line is, if tobacco sales are removed from pharmacies, our rent would increase.

To restrict sales in the front store will impair the stability of the interdependent structure of dispensary and front store. This will be a more damaging blow because the current government has already restricted dispensary profit by reducing our fees after a three-year freeze. If the front shop fails, the hours of operation will likely be restricted and the patients in my community will have restricted access to their pharmacist, the one front-line health care provider they can rely on to be available to them without an appointment.

Bill 119 will not achieve its goals by banning tobacco sales in retail pharmacies. This section, section 4(2)8 of the bill, will instead result in lost jobs, reduction in hours of operation of pharmacies and consequently in families losing access to a valuable member of a health care team in their local community.

I hope that my comments and views will be of assistance to this committee in its deliberations over Bill 119 and I would be happy to answer your questions at this point.

**Mrs Haslam:** We've been on this committee for a couple of weeks and I think we've heard this argument from some of the chain drugstores before. It always amazes me that this committee's going to have to come to a decision and now, given that the federal government has just lowered the taxes on cigarettes which will increase possibly the number of people who smoke, I think it's incumbent on us to be very strong in this legislation because we have to be.

I'm always referring back to other presentations that we've had made to us. The Lung Association in London and Middlesex did a presentation where it said that in the Canadian economy lost productivity and wages due to smoking-related illnesses and premature deaths account for an estimated \$5.4 billion yearly, as a loss and as an additional \$1.5 billion yearly spent on hospital care and physicians' services for these illnesses.

When I have chain companies come and say, "Bottom line to us it is a cost item," bottom line maybe to the government, we have to look at it as a cost item too, only our costs are \$5.4 billion yearly to the economy and \$1.5 billion yearly on a budget out of \$17 billion, a third of our budget going into the health care costs. We have to look at 13,000 premature deaths a year.

When we have presentations come here, I'm concerned that we hear that there's a loss of some jobs and it's not easy, that there'll be a loss of profitability for some druggists, and then on the other hand we have pharmacists come in and say: "I did it. It used to be 10% of my business and I didn't go under. I was able to maintain my integrity as a health practitioner without losing the business and by replacing it with other products."

**Ms Braden:** Different stores may be able to do that.

**Mrs Haslam:** I agree. I hear chains come in and say:

"You're not going to reduce the volume when you take it out of only our store. We would like a level playing field." I have other pharmacists come in and say: "That's why the college of pharmacists wanted you to bring this in, because we do need a level playing field. Voluntarily, it's not working out there. Voluntarily, our pharmacists are not following what their own college has put in place, for various reasons, depending on the chain store you're located in, depending on whether you are hired by a store or whether you are an owner of that store and look at the front line as a profitability."

I must tell you that the one thing that did bring it more to my attention was when Lambton county came in, because up until now we've heard pharmacists say, "We're the ones who are more precise in how we control the tobacco." In Lambton county 36% of the questionnaires that went out to their own local high school—36% of the students said they had access through pharmacists. To me that says we have to come to grips with this and maybe it's time we did play a very hard line in this situation and come to terms with that. As pharmacists, don't you feel it's time you took a hard line and said, "Bottom line maybe isn't profit this time"?

**Ms Braden:** I appreciate your concerns and I have no argument that it isn't a major health risk and a major concern for all of us. I don't agree that Bill 119 is a method of effectively dealing with it and I maintain that tobacco is a legal substance and we are responsible in our manner of selling it. Over time the marketplace will gradually diminish in its sales in pharmacies and that will be accomplished in a voluntary manner as we reintroduce different product mixes, but we cannot be legislated—

**Mrs Haslam:** It hasn't happened since 1990, when the college introduced it. It was supposed to have worked in four years. What kind of time lines do you think the chain drugstore or your drugstore is going to need if it's not done in four years?

**Ms Braden:** I can't speak for the chain I am employed for; I can speak as an independent pharmacist. I believe change does take time and I believe we will need to reassess our position in the community as far as what we sell as retailers but that it cannot be legislated. It is a process of education, of educating particularly our young people and being out in the community.

**Mrs Haslam:** Which, as Mrs Cunningham has said, is not exactly working and we have to—

**Ms Braden:** If I'm allowed to maintain my store in my community, I can maintain my influence on the young people I come in contact with. If I'm closed, I cannot do that.

**Mrs Cunningham:** I'm going to remind my colleague that the main focus of the Middlesex-London Lung Association was on the workplace and the need for more legislation.

**Mrs Haslam:** But the facts are there.

**Mrs Cunningham:** Yes, but they never made any comment on the point of sale. They did make a lot of comments on the workplace.

**The Chair:** We'll keep questions and answers to the witness, please.



**Mrs Cunningham:** Yes, it's hard though, isn't it, when somebody else has spoken. I'm just correcting that.

**Ms Braden:** The Lambton study is perhaps an unfortunate anecdote. The Lindquist Avey study does define that tobacco is sold most responsibly from pharmacy retail outlets rather than other retail outlets and that's quite clear.

**Mrs Cunningham:** I think this morning the students who were before the committee also said that, which is quite interesting. From our point of view, where we're looking at this issue, we certainly support your position because we feel that the emphasis has to be on licensing the person, in fact the retailer, that's selling the cigarettes. I wonder what your opinion would be on that. Also, the health unit in Essex-Windsor also stated that it was important that the young people take responsibility and that perhaps there ought to be some fine or some deterrent to young people who are indulging in illegal activity.

**Ms Braden:** I agree.

**Mrs Cunningham:** I wondered what you would say about having to be licensed as a drugstore in spite of the fact that I think basically you people are asking for identification more than anybody else. What would you think about the young people who are smoking off the school grounds—we hope, if they have to smoke, we wanted this thing to be a school grounds thing. What would you say about going after young people with fines and what would you recommend?

**Ms Braden:** I believe they should be called to account for their behaviour and certainly waiting until they're 19 years of age—they should be able to account for their decisions prior to that. I believe in the licensing of establishments to sell tobacco. That would create a sense of educating of retailers. It would bring everyone on line with the enforcing of the age restriction.

If we were to establish an identification similar to several years ago, back in my university days, the age of majority card—perhaps something like that could be established that could be used as an effective photo identification for students or minors who are coming of age, so they could be identified by all retailers. By educating retailers I think you would obtain cooperation from those who right now are perhaps a little lax.

**The Chair:** Thank you very much. I'm sorry that our time is going to have to end the questions, but we also wish you a safe trip back to Barrie.

1400

CANADIAN CANCER SOCIETY,  
ONTARIO CENTRAL WEST REGION

**Ms Bonnie Hauser:** Thank you for allowing me to stand before the committee. I'm Bonnie Hauser and I'm a representative of the Canadian Cancer Society. I'm the health promotion chairperson for the central west region. The central west region is the Golden Horseshoe, Niagara, Kitchener-Waterloo, Brantford, Halton and Haldimand-Norfolk.

The Canadian Cancer Society is a volunteer-driven, non-profit organization whose mission is the elimination of cancer and to enhance the quality of life of people living with cancer. My voluntary position as health

promotion chairperson is to enable people to take the responsibility for cancer control by adopting lifestyles that will promote prevention, early detection and early treatment of cancer. The cancer society feels that Bill 119 is a crucial legislative framework which will enhance our efforts to improve the health of the people in our province.

The reduction of tobacco use will greatly reduce the incidence of tobacco-related cancers. Tobacco contributes to 30% of cancers and 85% of lung cancers. Over 90% of the people who smoke start smoking before the age of 17. The initiation of tobacco use and becoming addicted—people become addicted between 12 and 15. If we can stop them from smoking before that age, we will prevent them from becoming addicted to tobacco use. I feel that Bill 119 will help this by increasing the legal age to 19, eliminating the kiddie packs by imposing proper packaging restrictions and eliminating vending machines, which are easily accessible to minors.

Bill 119 promises to help reduce the availability of tobacco products to minors. By increasing the age to 19, they can use the age of majority cards to identify people, which would make it a lot easier to regulate the sale.

Vending machines must be removed so that the sale of cigarettes can be monitored. If we reduce the access of cigarettes for minors, we will reduce the amount of teens who will begin smoking. Some 3,000 teens per month join the tobacco market, and 36% of these teens will die of tobacco-related deaths before they reach the age of 70. The health costs of this are phenomenal.

I've included in my report some statistics for the central west region. As I was writing these numbers down, it became very upsetting. It just seems like statistics, but 21,000 people in the central west region died of tobacco-related diseases in a 10-year period. That's scary, and it seems to be increasing. That was a total cost of close to \$66 million in health care. We should address this. I think that Bill 119 is going to help restrict the amount of people who start smoking younger and therefore restrict the amount of people who die of tobacco-related diseases.

It's really surprising in the area that I live in that the Haldimand-Norfolk separate school board and the Norfolk public school board still allow smoking on their premises. I really feel that Bill 119 will help eliminate smoking on school properties. We all know that if teachers are found smoking, it's a role model for children, Mr Eddy, and this should not be allowed.

In a public opinion poll that the cancer society was involved in, done in September and November 1992, they found very strong support for tobacco control measures which would keep children and teens from buying tobacco. One third of the people who were polled were smokers themselves, yet 81% of these people supported legislation to restrict access of minors to tobacco products and 75% of them wanted a ban on vending machines to allow cigarettes to be sold only at licensed retailers who will require the showing of proof of age cards.

I have several statistics in my pamphlet, but I'll just highlight some of them.



Seventy per cent of the people who were polled felt there should be a ban on cigarette smoking in indoor public places. This is really interesting because 33% of these people are smokers themselves, so it sounds like 6% of the smokers actually want a ban in public places also.

Sixty-four per cent of them cite that lung cancer is the primary danger of tobacco smoking. The general public realizes that tobacco use is not healthy, and I think the general public really wants them to do something about it. The introduction of Bill 119 will help address some of these concerns and will help give the public the legislation they require.

One of the areas that I am personally involved with is I am also a pharmacist. As a pharmacist, my husband and I own Hauser's IDA drugstore in Dunnville, Ontario. There are two drugstores in our town, and we made the decision in 1982 to eliminate tobacco products from our drugstore. This decision was very difficult because, as you know, there is a financial implication to reducing the sale of a product that you have in your store. Ethically we felt that we could not be true health care professionals and continue to sell a product that we knew causes severe health problems.

Surprisingly enough, this was a very positive decision to make as far as retail went. We became the professional pharmacy in town. The other pharmacy was known for selling the cheapest cigarettes. People came to us because they wanted to receive professional information from a professional store. We had a patient who went to the other store to buy his cigarettes and came to our store to get his prescriptions because he felt he was getting professional service at our store. We got a lot of positive feedback as far as customers praising our decision, and I think we even had new customers come in to our business.

Some of the pharmacists think their business will collapse if they're not selling cigarettes. Last year in the summer our competitor took out his cigarette products, and even though his claim to fame was selling cheap cigarettes, he's still in business and doing quite well. My brother also owns two drugstores in Port Colborne, and he eliminated tobacco products. His competition was Shoppers Drug Mart. He picked up many new customers. People were very supportive of his decision. In the Hamilton area, the Dell Pharmacy chain has removed tobacco products voluntarily from its stores too, and they are still in business. If a drugstore is going to go out of business from removing tobacco products, maybe they should be opening a smoke shop, not a health care establishment.

These opinions are strongly backed by our governing body. The Ontario College of Pharmacists strongly recommends that pharmacists remove tobacco products, and Bill 119 is the legislation that will make it a universal decision. The Ontario Pharmacists' Association also encourages voluntary cessation of the sale of tobacco products. In a survey vote in the fall of 1992, 62.1% of pharmacists supported the voluntary withdrawal of tobacco products.

A lot of pharmacists are afraid of this act, and I think

it's because they feel the decision is being taken away from them. But when you explain to them that it's the Ontario College of Pharmacists that has tried to encourage this committee to introduce the withdrawal of tobacco products from pharmacies, I think they understand that it is a really positive decision. Pharmacists must make their business the business of health, and tobacco products have no place in a pharmacy. Bill 119 reflects this position and enforces the pharmacist to uphold the recommendation of the college of pharmacists.

In conclusion, I think the cancer society believes the government will receive strong support for Bill 119. As a volunteer of the society, I know that my fellow volunteers and the people who donate to our society are concerned about tobacco sales to minors and wish that tobacco use could be reduced or eliminated. As a pharmacist, I know the majority of pharmacists are willing to remove or have already removed tobacco products from their stores. I feel Bill 119 will help to reduce tobacco use and in turn reduce the incidence of cancer.

Thank you very much for your time.

1410

**Mr Eddy:** Thank you for your presentation and indeed your own story of how you've eliminated the sale of tobacco in your pharmacy. I think that's good in your connection with the Canadian Cancer Society.

Realizing the concern that most people have about youngsters starting to smoke and realizing your support of Bill 119 as it stands, are there any other things that you think should be included that would help this situation? I know a great deal of it is through the contraband tobacco situation, of course, but are there other things that you think should be included in Bill 119 to strengthen it in regard to the point of youngsters starting to smoke?

**Ms Hauser:** I guess education is the main thing, if we educate people to the deterrent factors of tobacco use. I guess if people aren't allowed to smoke in public places, it won't be seen as a glorious image of smoking, and if it's kind of put to the back rooms or the outside, it won't be as convenient. I think that may help youngsters decide not to smoke. I think they start because they think it's a defiance of authority, but if you make it an uncool thing to do by kind of making it a backroom thing and not allowing smoking in any public places—there are a lot of communities that still don't have that bylaw.

**Mr Eddy:** Yes. Unfortunately, that's true. Thank you for your response.

**The Chair:** Thank you very much. I'm afraid we have a very tight agenda this afternoon so I'm going to have to close it off there, but thank you again for coming. Safe trip home.

**Mr O'Connor:** If I might, Mr Chair?

**The Chair:** Oh, yes. Sorry. The parliamentary assistant just had a couple of documents.

**Mr O'Connor:** As a result of this morning's announcement by the Prime Minister of Canada, I've got a copy of the press release and the fact sheet related to it, and I also have a press release from the Treasurer of the province, Floyd Laughren, who has been deeply disturbed

by the federal move. I would like to table that and circulate it to the members of the committee.

HOWARD LACKIE

**Mr Howard Lackie:** Mr Chairman, ladies and gentlemen of the standing committee, I'd like to take this opportunity to thank you for allowing me to make this presentation today. My name is Howard Lackie, as was stated. I'm a pharmacist, a fellow of the American Society of Consultant Pharmacists and also the American College of Apothecaries. I'm very much committed to community health care, as are my wife, who is a physiotherapist, and my daughter, currently a resident in obstetrics and gynaecology in this city. I own two pharmacies in St Catharines.

I apologize, as I indicated to the clerk earlier, that I do not have copies right at the moment, but I will provide them. In fact I had prepared the 25 copies as was required to make my original submission to you, but after reviewing and watching what has been going on here during the last week and hearing what has happened this morning, I wanted to say something a little different. So, please, with your indulgence, I want to bring a little different perspective to the issues. I am prepared to hand in this presentation as I've finished it earlier today and will provide you with more copies.

Forgive me: I am not a lobbyist. I'm a simple pharmacist. I'm there on the front lines. I deliver health care. I counsel with my patients. I fill their prescriptions seven days a week, trying to make a living for myself and providing employment for 65 people in my two pharmacies. I own and operate two Shoppers Drug Mart stores in St Catharines. One is located at Port Plaza near the infamous Port Dalhousie, and the other at North End Plaza on Lakeshore Road, also in St Catharines.

Now, please, I'm not one of the bad guys, because to the casual observer watching this scenario and witnessing these proceedings, that is what this debate has turned into: the good guys who don't sell tobacco and the bad guys from Shoppers Drug Mart. Because our parentage and our relationship are associated with Imperial Tobacco, the bad-guy image of Shoppers is of course taken for granted.

For the record, Imperial Tobacco cares as much about me as I care about them, and that's not very much. There's absolutely no love lost in our business relationship. Again for the record, you might refer to the two sales representatives who just called on me this past week or two. We are two separate and distinct corporations in a holding company known as Imasco. I don't even think that the Imperial Tobacco workers in Guelph shop in Shoppers Drug Mart stores. They certainly don't shop at my Shoppers Drug Mart. I'm not my brother's keeper in this regard, and they're not concerned about me either.

As you have heard, there are about 1,400 pharmacies in this province who could be classified as the bad guys, and the balance of the 800 are the good guys. But as you know, the problem is not that simplistic. I only wish this issue was as black and white as it seems to appear. As you are well aware, it is a very, very complex problem. In fact there are over 2,200 pharmacies and over 7,000

pharmacists in this province who abhor tobacco. I don't believe there is one single member of our profession who condones its use or truly approves of its sale. If there is, then he or she is from a completely different planet.

Your proposed legislation is a good piece of legislation. I believe if I asked all of you, those who are here right now anyway, members of the standing committee, if this legislation did not contain the provision that's referred to as section 4(2)8, would you vote right now at this very minute for its implementation, I think there would be a unanimity in this room without any question. The Liberals, the Conservatives, the NDP government members, all of your hands would go up. Shoot them high. You would vote a unanimous yes, almost a historic, unanimous yes, and tomorrow morning it would be passed.

The quicker we get the 19-year-old provision in and the sooner we get serious about finding vendors who break the law the better. Every day lost in that regard is another day wasted. But obviously, this section 4(2)8 is the clause that has slowed down the implementation of this act. This is what's making us sit here for these long weeks.

It was while I was watching the proceedings on the parliamentary channel—I never, ever thought I would watch that thing—that I decided to discard my original presentation. It was because of the nature of the questions that had been asked by all party members to the pharmacist presenters particularly. I see Mrs Haslam has vacated the room, but I know she's been asking the same question, and please believe me, I believe that question is right on. It goes to the heart of the matter and it addresses the fundamentals of this issue.

She's asking, "How can you be a pharmacist and a health care professional and operate a health care facility while at the same time you're selling a product which negates that very purpose?" That question is absolutely the right question for all of you; not just Mrs Haslam, but all of us. We present that question. It is absolutely the issue and the question.

I have to tell you personally that as a health care professional operating a health care facility, it is incongruous that I sell tobacco. It's a paradox; it's a conflict. There's no doubt about it. Absolutely. But all of you members on this standing committee, all of you honourable members, I presume, have to realize that a pharmacist is not only a health care professional.

In the same way that the government of Ontario is made up of different portfolios and there are different ministries in the government, so is pharmacy made up of different portfolios, and there are different ministries and disciplines within a drugstore. In the universality of a drugstore, we're composed of different parts. In the same way that the Ministry of Health obviously finds tobacco reprehensible, while I am wearing my white coat and I am serving in my dispensary and I am like the Minister of Health, tobacco is likewise unacceptable.

1420

However, the Ministry of Finance and the Ontario government need revenue from all sources to pay their



bills. The Ministry of Finance needs taxes from liquor, from beer and wine sales, from gambling, yes, even from Pro-Line—we'll find out what the basketball situation is—and even from tobacco.

The Ministry of Finance takes that money to pay the bills of the Ministry of Health, and while I am proverbially wearing the Minister of Finance's hat in my drugstore, my responsibility goes beyond the dispensary. I have to create enough revenue to pay the bills at my pharmacies, to pay the salaries, wages and other expenses incurred in the operation of both of my drugstores. The pharmacy itself is not self-liquidating and does not cover the costs for the balance of my store. Maybe that's an issue for a whole different committee meeting. We'll leave that one at this point.

When I am acting as the Minister of Labour, I have to create employment opportunities for the 65 people who work in my two stores. Remember, as some of the earlier speakers said, I also come from a community that has been very, very hard hit in the labour force. General Motors is the major employer in the St Catharines-Niagara community.

Please forgive me for my analogy to this series of Politics 101, but that's exactly how a pharmacy and a drugstore operate. In the same way that the government wears many different hats in different ministries, in different portfolios, and in the same way that some departments raise revenue that may be incongruous or in conflict with other departments, your ministries are inexplicably bound together by virtue of the fact that you are a composite body. You are a cabinet. The pharmacy is one part of our business; the drugstore is another part of our business.

As I might term myself in this context, as the Premier of two Shoppers Drug Marts—I've lost some of my notes. Just one moment.

**The Chair:** Take your time. These things happen.

**Mr Lackie:** These things do happen, yes. I normally like to talk off the cuff, but because you did ask for 25 copies, I'll see if I have some of my original notes when I redid them on the computer. No, I don't, so we'll use a little bit of cuff work here.

**The Chair:** It's all right. You can take a moment to sort your thoughts out. We have time.

**Mr Lackie:** I'm referring to the differential and the comparative nature of the government and its different ministries and their responsibilities and my responsibilities. I have to emphasize that I wear those same hats that the government wears. I have to look after all of these same different ministries. There is a conflict there, but I still must be able to make that balance. That balance is one that I have a lot of difficulty with, as I indicated before, because there is a conflict in terms of the health care issue and in terms of being able to maintain my pharmacy in a viable fashion.

In this particular situation, I think there are some other issues that may be of concern. I'd like to refer to another point and that is with regard to the Ontario College of Pharmacists. They had asked this government to bring this legislation into place and put it into place, and this

government is merely reacting to that particular request.

In June 1991, the district representative for the St Catharines-Niagara Peninsula was Donna Sutherland. In subsequent elections, which were held a couple of months after that in August 1991, Donna, who had voted for tobacco removal, was herself removed in that election by a 63% majority. Our profession was clearly unhappy with Donna's position and we expressed it in our vote, just as what happens to each and every one of you when you're out there and you speak to your constituents. The vote is the final thing.

A new representative in that particular jurisdiction took a different opinion and I believe that opinion represented the majority of the pharmacists on this particular issue. I also think, and I'm sure you've heard this before, that in a survey done by the Ontario Pharmacists' Association, 62% of the members of that association indicated that they are in favour of the legislation but without section 4(2)8.

The profession is clearly divided. Even in just this past three quarters of an hour you have heard pharmacists who have stated both pro and con. That is an issue which I feel should be recognized. We are not unanimous on this particular legislation as it stands right now. We are unanimous I believe on the fact that we honestly feel that tobacco should be controlled and restricted, but on the actual way of doing it we are not unanimous. I believe you have to take that into account in your deliberations as well.

I apologize for messing up the last couple of moments of my presentation for you and I will try to get you a full copy of it for your records. At this point I'd be happy to answer any questions you might have.

**Mr Jim Wilson:** Thank you, sir, for your presentation. With respect to your latter comments about the feelings of pharmacists, I did my own survey, mailed to all of the pharmacists in the province of Ontario, and had 560 responses. Of those, 77% believe that the government should not impose this ban. Of that 77%, a significant portion of those were pharmacists who didn't sell cigarettes but still believed, on a business principle, that the government should not impose this ban.

I'm getting the feeling during these hearings that we're hearing from two types of pharmacies—the large pharmacies, with perhaps 7,000 square feet or more, and the smaller pharmacies, where the banning of tobacco products won't have as large an effect. I also suspect at the same time that those smaller pharmacies don't provide the same services that a Shoppers Drug Mart does, for example. Some stores have 24-hour service, Mr Bloom told us, in some cases home delivery, and a number of other actually quite unique things that Shoppers and some of the larger chains provide to their customers in terms of service.

I'm just wondering, if you're not able to keep tobacco products and the spinoff business that comes from the sale of tobacco products, will those customer services suffer? Secondly, can you give us a feel for what I think we're seeing as the two types of pharmacies, the smaller versus the larger merchandising pharmacies?



**Mr Lackie:** Let me answer your first question first. I'll pose it to those of you who are familiar with the Minister of Finance in the government. If the Minister of Finance is without the resources, without the money to do all the things that everybody else in all of his other ministries would like—I've heard the words "social contract" and "cutbacks" and all kinds of other things—what is the natural result? The natural result is that you cannot afford to do some of the niceties.

Has anybody ever tried to call a ministry office and instead of a person, because persons are expensive, you get a telephone and a telephone answering machine? At some point way down the way, because it's not high on the priority list, our service from the government has decreased.

There is absolutely no difference in my own ministries. If I have the Ministry of Tobacco without financing to provide for the Ministry of Health in my pharmacy, then absolutely there is going to be a decrease in services, and not because I want to decrease the services. If anybody knows me, my prime concern is service: service to the consumer, service to the patient. They are the only things that drive me.

1430

Your other question is with regard to the size of stores. If I understand it correctly, I believe, from my knowledge of the independents, the smaller independent stores, that their focus in terms of financial merchandising and overall focus is very, very different and very much away from anything other than a personal business that they conduct maybe 9 to 5 or 9 to 6. It's a one-person or two-person operation. Certainly their services are not there. They don't have the resources.

I noticed that somewhere later on today you're going to be hearing from a tobacco supplier who services these small people. You might ask him what kind of business they do and how much of an effect it really would have on them. I would venture to say, from my own personal knowledge, that it would have a minimal, if any, effect on them at all, but it certainly would have an effect on the way I operate my business today.

**Mr O'Connor:** Thank you for coming to the committee today and bringing across, again, another view from a pharmacist.

Earlier today we had a presentation from the York region public health department. They did a telephone survey quite similar to, I guess, Mr Wilson's survey. They surveyed 40 pharmacies from across York region and they found that 90% of the pharmacist employees supported the ban and 39% of the pharmacies already do not sell tobacco products. Those that didn't had positive comments from customers and people from the health community. Some 40% supported the withdrawal of tobacco and 15% of the pharmacies actually had planned to eliminate tobacco in the near future. That's 15%, so that puts it over 50%, I guess. Those that had tobacco products said it was marginal losses. I guess it's all in the marketing, and that's the retail end of your business.

One of the disturbing things that was pointed out to us, though, was that some of the owners who had not volun-

tarily withdrawn tobacco products said that they could not legally do so without legal action being taken by the parent corporation. I just wondered if you had been confronted with that type of a situation where the parent corporation for the chain—and they didn't identify themselves, for obvious reasons—felt that there would be legal action taken against them. I wondered if you had been confronted by that type of situation.

**Mr Lackie:** I have never been confronted by that. If you're referring to Shoppers Drug Mart, I know that there are a number of Shoppers Drug Marts that do not sell tobacco products. They are smaller stores. They are in medical facilities or health care units and they do not sell cigarettes. I can talk only for myself.

**Mr O'Connor:** And that's why I pointed out that they didn't name one. Of course, I wouldn't want to name this as just being Shoppers—

**Mr Lackie:** I can't speak for anyone else.

**Mr O'Connor:** —because it doesn't point to just Shoppers.

**Mr Lackie:** Right, there are other people in this marketplace.

**The Chair:** Thank you very much again for coming before the committee. We appreciate it.

MERI BUKOWSKYJ

**The Chair:** I next ask Dr Meri Bukowskyj. Welcome to the committee. We have a copy of your brief and attachment. Please go ahead.

**Dr Meri Bukowskyj:** Thank you. I won't be reading directly from my submission. I had actually presented this with overheads, but I'll just sort of flip through my overheads so I'm not reading directly.

I'm coming here to this committee today not as a member of the Non-Smokers' Rights Association, not as a member of the Ontario Medical Association, not as a member of Physicians for a Smoke-Free Canada. I support all those people. I know they've done submissions and I support everything they say. Why I am here today is because I wanted to present my views as a physician and as a respirologist, because I see the end results of tobacco every single day in my workplace.

I am one of the physicians who has to tell people that they have lung cancer. I am one of the physicians who has to tell people they have emphysema. I am one of the people who has to tell people that they're going to die. I have to tell people that they're inoperable and I have to tell people that they're going to be on oxygen for the rest of their lives. This piece of legislation is very important to me and I think it has to be very important to you as legislators.

In your list of things, I want you, at the beginning, just to keep in mind that smoking kills more people than alcohol, cocaine, crack, heroin, homicides, suicides, car accidents, fire and AIDS combined. We have to put it in the perspective of a mortality rate that is really extensive, and I'd like you to keep that in mind. Similarly, I'd like you to recall that the majority of smokers want to quit smoking, and five out of six wish they had never started, and that's an important fact.

Next, what I'm going to do is read to you a letter that is addressed to Mr Beer from one of my patients. This is a lady with very severe emphysema who is now relegated to staying in her bed, or walking a few steps to a chair, and is on oxygen 24 hours a day. She feels this issue fairly significantly now.

"I am a 72-year-old woman. Worked hard all my life"—this is her letter which I have Xeroxed for you—"and should be enjoying my retirement. I had my first cigarette when I was about 16. As years went by, my smoking increased to a pack a day for the past 40 years.

"I was advised by my doctor a few years ago to put out my cigarettes before I would ruin my health. Putting a deaf ear to this I carried on smoking until it was too late. I now have emphysema and was diagnosed for this in 1988.

"I would gladly give 10 years of my life to be able to breathe normally. It is no life to be hooked up to a tank of oxygen for the rest of your days.

"I would like to say, if you are a smoker now, quit. If not, don't start. Take this advice from one who is living a life of hell."

I think you should put that into perspective. She's not alone. There are a lot of other people who are living a life of hell that they had no idea that they were going to have to live through because they started to smoke.

You have to understand that smokers deny, as she did, their personal risk of ever developing illness. You ask kids who start to smoke, "Do you know the risks of smoke?" "Yes." "Is it going to happen to you?" "No." They deny. Smokers deny their addiction. There is no way that they understand the level of addiction that is induced by nicotine. They have no comprehension. You ask kids, are they going to be able to quit smoking in the next year? "No problem." Come back to them five years later, most of them are still smoking.

They don't understand the level of their addiction, nor do people who have never smoked understand the addiction to nicotine. I don't understand it. I'm a never-smoker, but I can certainly have a great deal more empathy with the patients whom I've seen, their level of difficulty in trying to quit smoking and all the extensive reading I've done on addiction. But I think one of the problems is that people who have never smoked don't understand, and that's part of the problem for smokers.

One of the things you have to understand is that nicotine from an inhaled cigarette reaches the brain in seven seconds. There is nothing else that gets that fast to your brain, not even intravenous drugs. That gives you virtually immediate reinforcement of your addiction. Nicotine, as I said earlier, is as addictive as heroin and cocaine. Appreciate that. These people are drug addicts. They could be in New York City in the ghetto. But they don't like that analogy, they don't like that comparison.

You also have to understand that there's an incredibly high rate of failure for people who try to quit smoking. At the end of a year, only 8% of smokers, as a total group, have stayed off cigarettes, a 92% failure rate. It's unbelievable. It's a lot more difficult to quit than it is to prevent, and if we can prevent our children from starting

to smoke, they won't get into this difficulty of trying to quit an incredibly severe addiction.

Most children, as you're aware, start to smoke between the ages of 10 to 14. Unbelievable. Think about alcohol. You're not supposed to drink before age 19. You don't vote, you don't drink before you're 19, but you're allowed to smoke. There's a very interesting statistic: Alcohol is responsible for about 2% of all deaths in Ontario in 1992. How many deaths were caused by tobacco? It was 20%. But we don't regulate tobacco. No, no, we regulate alcohol. I think we have to do something a lot stronger.

I think Bill 119 is a really good start. I think this government deserves a lot of credit for introducing this bill. I find it incomprehensible that any member of the opposition would not support this bill. It's just untenable that we would not do something to prevent our children from becoming sick.

I, in general, support the provisions of the bill as they stand. What I'd like to do is just go through several of them that I would like to see improvements on.

First of all, I think that restricting access is very important. I think now that the federal government has gone ahead and made this horrendous mistake in lowering taxes, we have to make this bill a lot stronger to protect people in Ontario. I think we should do a lot, lot more.

Licensing: Fine, you can start, but I think that all tobacco should be sold in LCBOs. Get the age of majority. You don't have to do any extra amount of licensing involved. They're already in place. They just have to put up a couple of extra shelves with their packets of poison and they can sell them in places that are already restricted. That will not only limit teenagers; it will also limit where adults can get cigarettes and it will make it harder for them, especially now that the federal government has made it easier for them in terms of costs.

#### 1440

The pharmacy ban: I'm sorry, I very much support having a pharmacy ban. I don't see how you can call yourself a health professional and sell, at the other end of your store, a tobacco product which ultimately results in death. It's not acceptable.

I think, once again, that the federal government has not done enough in terms of packaging and the health warnings. As you know, the Tobacco Products Control Act has a statement in it that allows the provinces to do more. I think that in fact this government should do more in terms of putting warnings on the packages and introducing plain packaging. If the federal government's going to pull the rug out from under us, then I think we should do something more.

I think in fact that smoking should be prohibited in designated areas. In my community we can still smoke in malls. You can die walking through some of the malls in Kingston. You can go into the hospitals. Their designated area is an area that's outside of an elevator where patients are transported. The smoke is thick and yet this is a hospital, a designated smoking area? I think this provincial government should do something that will actually protect not only the patients but the people who go into



the hospital. I think that kind of legislation would make it fair to everybody throughout the province.

I think kiddie packs are an abomination. I think there should be a minimum size. I would make it larger than it is now, so that it becomes incredibly more expensive, especially now that the federal government has done what it has. Make the smallest size of the pack 40. That'll make it more expensive to buy. Children can't afford it. Nor will some of the adults who are on the borderline.

I think the other thing that needs to be addressed, although I realize it's not part of Bill 119, is smoking in the workplace. It is something that needs further legislation because it does not adequately protect workers. I think that's something that you should consider revamping.

In closing, what I would like to say is that the tobacco industry did not elect you or any part of this government; the people did. I think it's your responsibility to protect us and our children. Thank you.

**Mr Tony Martin (Sault Ste Marie):** I want to thank you for coming forward and for your very clear-cut, decisive way of presenting. Certainly there was no doubt in anybody's mind about where you stood on all of these issues. I don't think, from listening over the last couple of weeks to the discussion that's gone on here and from the presenters, there's any doubt in anybody's mind that smoking is not, in any way, a habit that we should be supporting. It is in fact dangerous to one's health and is a cost to society as a whole that is preventable, at minimum.

The debate or the issue at this table seems to be around how much we should still allow smoking or the sale of cigarettes to be available and one of freedom to market and those kinds of things. Certainly the provisions in this act that are under some contention are the sale of cigarettes in pharmacies and the removing of vending machines. In your mind, is there any debate at all around the question of whether we should be selling cigarettes at all?

**Dr Bukowskyj:** Oh, if I could do it, I'd have a decree and you couldn't sell cigarettes at all. But I think you have to understand that a large portion of the population is now addicted. A large portion of the population that is now ill from their smoking started smoking during the Second World War and earlier when there was nothing known about tobacco. The Red Cross used to give out cigarette packages to the armed forces.

I think it's very difficult to remove a product that we now know is so dangerous, even though it's not legislated or controlled as much as it should be. I think all we can do is control it more and more and ultimately remove it. But I think a hundred years from now people are going to look back at us and say: "How in heaven's name could you have allowed this to happen? You knew all these bad things and yet you allowed people to continue to buy it and to smoke it and to die. How could you do it?"

**Mr Martin:** Just another little piece—Jim wanted a question, if he has time—is the onus of responsibility. Right now, we're certainly putting the onus on the adults in the community who sell these products to make sure

that they don't sell to children. There's some suggestion that maybe the onus should be more on the children who buy the products. What's your sense of the fairness of that?

**Dr Bukowskyj:** I think it's your responsibility as adults. You have to remember that kids are kids. How many stupid things did you do when you were a child? I think we have to protect our children. That's why we have an age of majority.

**Mr Jim Wiseman (Durham West):** I was a Tory when I was a youngster.

**Mr Jim Wilson:** Thank God you switched.

**Mr Wiseman:** I saw the light.

**Dr Bukowskyj:** Anyway, I think it's important. Yes, I agree actually and I had never thought of that, but I think putting a fine on children for smoking is important. But I think it's also important for adults to protect them because you don't know enough. You don't know until you're older what the hazards are, nor do you internalize them. So I think I agree with both.

**Mr McGuinty:** Obviously you are a very committed advocate and you make a compelling case.

I want to refer to the words of a presenter who appeared before you, "You know, it would be nice if this was all black and white." I guess it's like so many of the issues that we have to deal with here in government, if we could be pro one side and anti the other, depending on which particular interest group we're dealing with. But of course this is a complicated issue as a result of the history that has developed over the tobacco industry in this province.

Even today, in the press release put out by the Minister of Finance for the government that is sponsoring this bill, which is a good bill—by the way, I'm not aware of any single member of the opposition who's voting against this bill, just so we're clear about that. That Minister of Finance said, "Ontario stands to lose hundreds of millions of dollars a year from lower revenues if we cut our taxes." I'm not criticizing him for that whatsoever. That's a very legitimate expression of concern on his behalf as the Minister of Finance.

The Health minister of Canada expressed some very serious concerns about reducing the tax.

**Dr Bukowskyj:** When? I didn't hear her say a word.

**Mr McGuinty:** Well, she did. Again, I think that's a very legitimate expression of her concerns about that issue. It's a broad issue, it's complicated and this piece of legislation, like any piece of legislation that's ever been put out by any government anywhere at any time, has some imperfections, so we're trying to address those here.

I want to come back to this issue of youth responsibility. How is it that, if we're dealing with something like alcohol, it only accounts for 2% of all deaths but we're distributing the darned thing through a tight network of regulated stores and we're telling kids it's illegal for them to drink when it only causes 2% of the deaths? Why aren't we doing the same thing with cigarettes?

**Dr Bukowskyj:** Exactly.

**Mr McGuinty:** Just so I'm specific, you're prepared



to impose some kind of sanction against kids if they buy cigarettes below the age of 19?

**Dr Bukowskyj:** Sure.

**The Chair:** Dr Bukowskyj, I'm sorry that we don't have more time but we thank you very much for coming.

**Mr Wiseman:** Mr Chairman, since I didn't get a chance to ask my question of the doctor and since this is only my first day on this committee, I would like to see a breakdown of the frequency of visits to a doctor of a person who smokes, the cost per visit and see the fee breakdown that a doctor would be able to charge on these cigarette-related visits such as cancer, emphysema, the asthma or whatever, just so I can have some idea of the magnitude we're talking about. I think that the public really doesn't understand what it's costing the system and I would like to see those numbers so I can talk about it in a more precise way.

**The Chair:** Just because of our time problem this afternoon, if we could take that under advisement and just work on out—

**Mr Wiseman:** Oh, I don't want it now.

**The Chair:** We'll see what we can get together.

**Mr O'Connor:** I appreciate the time because it may take a wee bit of time to compile that information.

**Mr Wiseman:** That's fine. Eventually.

1450

#### COUNCIL FOR A TOBACCO-FREE ONTARIO

**Ms Alwyn Robertson:** Good afternoon and thank you, Mr Chairman, members of the committee. My name is Alwyn Robertson. I'm the executive director of the Council for a Tobacco-Free Ontario and I'm very pleased to be here and to be joined, to my right, by Mrs Norma McGuire, who is our vice-president of administration for the council and who has also made an earlier presentation. She sits on our council as a representative for the Ontario Federation of Home and School Associations. To my left is Dr Michael Goodyear, who is our vice-president of public affairs and is also the representative for Physicians for a Smoke-Free Canada—Ontario on the council.

What I'd like to do is just to briefly describe to you the nature of the council and its membership and then I will turn the microphone over to Dr Goodyear, who can talk to some of the substantive concerns that we have at the council about Bill 119.

First of all, I would like to offer the council's congratulations to the government for introducing Bill 119 and also our thanks to members of all parties for supporting this piece of legislation. I hope that you're finding this hearing a very interesting process as you're listening to all of us come before you.

The Council for a Tobacco-Free Ontario began its life about 20 years ago as the Ontario Interagency Council on Smoking and Health, and we were set up with representatives from some of the major societies: the Canadian Cancer Society in Ontario, the Heart and Stroke Foundation of Ontario and the Lung Association, along with approximately 30 health and professional associations.

I'm pleased to report that almost 20 years one of the

things that the interagency council was to do was to encourage joint action with agencies in promoting legislation and education. Today the Council for a Tobacco-Free Ontario is still very much alive and kicking with very much the same mandate and membership of those original organizations for 20 years.

The council is a resource centre. It is part of the Ontario tobacco strategy. We have a total of 38 local councils on smoking and health in communities all across the province. The council represents the grass-roots component of Ontario's efforts to promote smoking cessation messages across the province.

We have linkages with major health care and professional organizations. You will see a list of some of those organizations at the back appendix to our report to the committee. We also do a number of things to educate people about tobacco issues, this being an example of one of the things that our committee has put together towards the smoke-free class of 2000.

This is being distributed to all grade 6 classes across Ontario and represents a way to help teachers teach young students about tobacco and the messages. We're trying to work with the community and get people together about a very common issue that's of great concern to people and we represent a lot of volunteers and individuals within the community.

I would just like to close by saying that the council supports this piece of legislation. Ontario needs it. It's very encouraging to think that we've been around, on the one hand, for 20 years and unfortunately we're still here because the problem still exists. Thank you. I'd like to turn the microphone over to Dr Goodyear.

**Dr Michael Goodyear:** Good afternoon. Your timing is certainly impeccable in terms of when you chose to have these committee proceedings in terms of the public interest. I'm sure you engineered it all.

I want to make a strong statement now, in view of the news today, that I wish to congratulate the very strong stand that the government of Ontario has made, and I hope with the support of the opposition parties, against the federal government's insane activities earlier today. It makes, obviously, the activities that you are designing in this bill even more essential, that it must make a major impact in reducing demand.

I would urge you as individual citizens of Canada and as parliamentarians and whatever links you have to bring every pressure you can to bear on your federal counterparts to reverse their policies. They can reverse their policies. Remember, it only took them eight weeks to reverse their policies in 1992, so public pressure does have an effect.

Our time is very limited. I would like to make time available for answering questions on any aspect of issues that have come up in the last couple of weeks that concern you and I would like to touch on a few things that I've heard.

First, and maybe a little technicality: This is a Tobacco Control Act and not, as in the federal legislation, a Tobacco Products Control Act. I would like to remind you that you need to make your definition of tobacco

rather broad. This is a packet of cigarette papers. Interestingly enough, it actually is in violation of the federal Tobacco Products Control Act. But since there are so few people in the country, I think about three, who actually enforce that act, provincial legislation that covers all tobacco paraphernalia is important. You may also be aware that most tobacco paraphernalia of course is used for other purposes than smoking tobacco. For instance, you can roll up and smoke all sorts of things which I won't mention on the public record.

This is a packet of cigarettes. Well, it's not actually; it's a packet of candy but, as you see, it's packaged to look very much like a package of cigarettes, Chicago. I haven't opened them. I don't have a sweet tooth. I think, as with a number of other jurisdictions, you should seriously consider including things that pretend to be cigarettes or tobacco products.

We have touched on the plain or generic packaging, which is an even more stringent regulation, in the past. This is a packet of smuggled cigarettes, which is very topical today. I'd just like to draw your attention to the fact that the label is written in French because, as you know, all Americans speak French and therefore we need to export French labels to the Americans. This is another reason why absolute control over the packaging and labelling I think is required, and that rather shoots the smuggling story in the foot.

But I do urge you to incorporate those sections of the federal legislation, as I mentioned to you the other day, into the Ontario legislation to make sure that it at least has the powers of the federal government in terms of concurrent jurisdiction.

I heard the other day people asking questions about licensing. Without surrendering our bottom line, which I think you've heard by now even from members of this committee, that we think the ideal solution would be to restrict tobacco sales to the liquor control board, somebody asked the other day—I forget which of you—what does licensing have to offer as opposed to the statutory prohibition?

Well, it's tangible. It's something you can hold in your hand. You've got a licence, it's something you hang on your wall and indeed usually you have to hang it on your wall. It's an exchange for money. When people actually pay for something they have a lot more respect for it, as most people can tell you. It can have built-in conditions. It has to be renewed, which means that it has to be applied for as well, that objections from the community can be applied just as in alcohol licensing.

Already we have British Columbia, Manitoba, New Brunswick, Prince Edward Island and probably Alberta that have licensing schemes, so you're not exactly going to be atypical if you have your licensing schemes. I'd also remind people here that the youth wings of all three provincial parties submitted a brief in 1989 requesting the then Attorney General to introduce licensing. So this is not something that is alien to the political philosophy of the politicians in Ontario.

We've heard a lot about pharmacies. I don't want to really discuss that because I think that's a perfectly

straightforward issue, as I said the other day, except of course that is only part of a limitation. Your licensing conditions could restrict the outlets to not only health facilities and pharmacies; obviously you meant to put in educational facilities. I think that was a slight oversight.

I'd also draw your attention to the national fire code, the fire code of Ontario and the Gasoline Handling Act of Ontario, that there are many places under the current legislation where tobacco consumption is illegal. It doesn't make a lot of sense to allow tobacco to be sold where tobacco consumption is illegal and presumably people could start a fire.

On the back page of our brief you will find an advertisement for pizza. If you look at a bit more carefully you will see that pizza now comes with cigarettes. We'd like to ask just how many adolescents who are great fans of pizza phoned for a pizza and were asked for proof of age when they asked for cigarettes to be thrown in there. We would like you to look very carefully at the list of designated places in terms of sales. This would certainly help some of those people who have been complaining about being picked on.

This morning I heard the question of possession raised, and I know I have touched on it before. The question was raised about whether children should be taken to court and fined for smoking or possessing tobacco. I would again remind you that the federal legislation does include forfeiture as a penalty for possession, and that legislation is due to be repealed some time.

In fact, may I ask the Chairman or the clerk to consider—I did actually have compiled at some stage a complete dossier of pertinent federal and other provincial legislation—whether making copies of those available to the committee would be useful or whether they already have that from their research officer. I can make that available, to see what's going on in other jurisdictions.

#### 1500

I was interested in the suggestion earlier about community service. I think community service that is oriented to the field, that is to say, where children could learn more about tobacco smoking and smoking and health would be, could be, an appropriate penalty. So could cleaning up the litter. That might bring the message home.

Any of you who have stood at a bus stop or at any other spot and have watched somebody who smokes and seen what they do with their packaging and the cigarette that they've finished with when the bus comes along will realize the large quantity—and I can give you some actual estimates—of packaging and litter that's deposited on our planet by the smoking community, which is certainly notoriously careless in its habits. So something along those lines could be an appropriate penalty for possession and for smoking underage.

Again, I have heard questions over the last few days in the area of sales to minors, about how you define the regulations there. I think I heard concern earlier about the current wording of the defence and I would strongly urge you that you use the current regulations governing the sale of alcohol in terms of controlling that.



I also draw your attention, since we've talked about concurrent jurisdiction a bit, to a clause in the act that applies to conflict such that the legislation, be it municipal or federal, that has the greater penalty or is more restrictive of smoking to apply. I think there's some ambiguity there because obviously there is some legislation that may be more restrictive and have a lower penalty, so clearly it should be "and" rather than "or". Also, of course, a tobacco sales offence as defined in this act is something contravening regulations of this act. Let me give you an example.

Many parents and teachers have complained in my community of vendors who are selling single cigarettes to children for 25 to 50 cents. This is of course a violation of both the Excise Act and the Excise Tax Act, federal jurisdiction, which is only enforceable by the RCMP now, although I hear the Quebec Provincial Police now want the powers to enforce that. A tobacco sales offence should be an offence against all pertinent legislation, not just against this act, to bring that under control.

Another small point: commencement. There is no commencement date in this act. You may not think that's important unless you study the jurisdictional history of other provinces and even federal legislation in this area and realize, for instance Manitoba has had an act sitting on its books now for two, I think, almost three years and is still writing the regulations. I know it's a lot of work for Brenda Mitchell over there in the corner, but I strongly recommend that you put a definite date on it and this will concentrate the mind, as I think that judges say when they pass the death sentence.

You've obviously heard that the other major area we're concerned about is environmental tobacco smoke. The other day I received a letter from the International Agency for Research on Cancer, a body you may not be very familiar with but it's a United Nations agency that sets standards for carcinogens and their regulation internationally. They stated in that letter to me, in response to an inquiry, that they now consider environmental tobacco smoke to be a carcinogen within the meaning of their regulations that they draft internationally.

I would reiterate to you that we now consider environmental tobacco smoke to be the commonest cause of death in non-smokers, which is a pretty major problem. I would again urge you to consider amending the Smoking in the Workplace Act. You are amending a number of other acts under this legislation so that you can consolidate the powers to bring that under control.

I recall that when the city of Toronto first introduced its city workplace legislation, I spoke to the people who manned the hotline several weeks later and asked them what sort of calls they were getting. It's rather interesting that the majority of calls they were getting were from people who thought they lived or worked within the city of Toronto, because you don't have to go through Customs to get out of the city of Toronto, who weren't. In other words, they got far more calls from people who wanted to be protected in their workplace than from people who objected to the legislation.

Finally, before we switch to questions, I have included a signal page, a cartoon taken from the Globe and Mail

on Thursday. When you set your final seal on this legislation, let you not be accused as the people who put a smiling face to death.

**Mr Wiseman:** You've certainly presented us with a lot of information. My question earlier had been with respect to total costs of delivering the health care that is necessary to take up the impact of tobacco smoking. We've talked a lot about negative things and about a lot of ways of trying to make a negative impact on smoking. Are there some things that should be done in a positive sense that could negate smoking?

We know, for example, that young women between the ages of 10 and 16 are the group who are the fastest-growing group of smokers. What could be done in order to turn them away from cigarettes in a positive way, as opposed to saying, "If you do this, we're going to do that to you," that kind of thing?

**Dr Goodyear:** As Larry well knows, because he was there at the time I actually asked a group of young teenagers of mixed gender this a few weeks ago, and we had reviewed the videotapes being used as commercials now, basically we said to them: "If you were given all the money in the world and you were allowed to make videos or commercials, what would you put in them? What would be the message you would want to give either to yourselves a few years ago, before it was too late, or to your younger brothers and sisters?"

They said, "We would want to make videos about the people who make a lot of money about peddling these drugs to kids and getting very rich while we get sicker." That's something they would really respond to, instead of being into necessarily scaring them with stories of lung cancer, which of course they don't really respond to very well. Is that something positive? It's something that appeals to their sense of autonomy, their sense of control. This is a drug which basically takes away their control over themselves.

Obviously we want to show them maybe what they could achieve. You could feature a lot of athletes who are non-smokers and show what they achieve, compared to a lot of puffing and panting people who will never make it to Lillehammer because they smoked. Is that the sort of thing you had in mind when you say you want positive images rather than negative images? I would agree with you. Sometimes we're referred to as the anti-smoking lobby, something that always upsets me.

**Mr Wiseman:** I guess what I'm giving you here is an opportunity on TV to give some messages to the parents out there, who could possibly do something in a positive way to prevent their kids from starting smoking. In that respect I'm even asking for myself, since mine are still young.

**Dr Goodyear:** As you know, the Ontario government has been distributing materials to parents and placing advertisements in the papers suggesting that they write in or phone in for that information.

Curiously, one of the things that came up in the meeting that Larry and I had with these teenagers is that actually we need information for the children to give to their parents just as much. Parents are exemplars and the



chances of you becoming a smoker if your parents smoke is much greater than if they don't, and if both smoke, even more so.

In fact, one of the problems that seems to be emerging at the moment, according to some teachers, is that children are taking home all these materials about tobacco and health from their schools and the parents who smoke are getting really upset about this and complaining to the schools that they're bringing materials home that are upsetting their parents. So this is a two-way dialogue. This is a very complex problem, with no simple solutions, or we wouldn't still be discussing it here all these years ahead.

**The Chair:** I'm sorry, I'm going to have to break it off, but thank you very much for coming before the committee today.

**Mr O'Connor:** Mr Chair, if I might, did committee members receive a copy of this booklet?

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Yes, we did.

**Mr O'Connor:** This is just the parents' guide to lead to a discussion between children and parents.

**Mr Wiseman:** Show it so the camera can see it.

**The Chair:** If somebody's looking at it, where would they get that?

**Mr O'Connor:** They can get it from the Ministry of Health. In fact, there were over 7,300 requests within the first 48 hours of the ads that were placed on the radio for this. I'll give this to the clerk, because he may get a few calls as well.

GEORGE PHILLIPS

**The Chair:** Our next witness then is Mr George Phillips. If I understand correctly, Mr Phillips, you have a Pharma Plus Drugmart here in Toronto. Welcome to the committee. Please go ahead.

**Mr George Phillips:** Thank you for having me here. I kind of feel overwhelmed by all of this, especially the people who have gone before me. I am just a simple community pharmacist. I'm fortunate to have 22 years' experience in this profession.

I got concerned when I read that the government's Bill 119 would effectively bar the sale of tobacco products from pharmacies. At first I thought the bill was a noble gesture with regard to its general theme, but the provision that bans the sale from pharmacies definitely threatens my livelihood, and that's why I'm here today.

1510

From the outset, though, I realized that the person or persons sponsoring this bill have been given incorrect information about my profession and that pharmacies and indeed the profession of pharmacy was being singled out for unfair and unusual punishment again because lawmakers do not seem to know how pharmacies operate in this society. Time and again you have attacked our profession, not caring about the hardships your actions will cause. For instance, do you realize that for corporate pharmacy to exist, we need to do more than fill prescriptions? We need to offer the public services and goods they want and expect.

I'm sure you've heard several submissions here about

the contribution to our bottom line that tobacco sales are responsible for in this society. The sale of tobacco products is a small portion of our overall profitability, but because a customer is in our store, he may purchase several other items which will contribute greatly to our bottom line.

Removing tobacco from our sales will only remove the opportunity for us to survive. You must agree that our overall profitability will be severely affected, and many drugstores will either close or reduce staff and hours. In fact jobs will be lost, and I have been advised that you already have the statistics on how many jobs could be lost in Ontario.

When drugstores close, not only will working people lose their jobs; the entire health care delivery system will suffer. Pharmacists are the number one community health resource. We counsel and advise the public on minor and major health-related problems—may I add, for free. We save the health care system a lot of money in this province by preventing the public from going to a hospital emergency department to seek help for minor ailments.

I am sure you recognize the dual role of the pharmacist. We are professionals and we are also retailers. You pay us a fee for our professionalism, and the government allows us a markup on our drugs simply because of our role as retailers. But it seems unfair to me that you are going to deny us our dual role when it seems to suit the government.

Tobacco is still a legal product in Ontario. People will smoke if they choose to. It seems to me that your efforts will be better served if you ban the product from other businesses also. Make tobacco illegal.

Today I appeal to you to help me to keep my job and maintain my family. Allow me to provide to your public the excellent standard of pharmaceutical care that all pharmacists provide. Think about the availability of pharmacies in rural areas of Ontario. These pharmacies depend more on allied sales in the stores than the ones located in well-populated areas.

In closing, I would like to say, would it not be ironic that in your quest towards a smoke-free society, you find it necessary to put so many restrictions on tobacco products that you make it a prescription item and put it in pharmacies, where we sell it to the public and control it because of the regulations that are inherent in my profession? I thank you very much.

**Mr Jim Wilson:** Thank you, sir, for your presentation. I think most, if not all, of what you've said makes perfect sense to me and my party. In fact, your latter comments about moving it into a pharmacy—it seems to me if you were taking a logical approach to this issue, that's where you would be heading. Unfortunately, we can't seem to—so far, anyway—budge the government on this issue, and it leads me to think that perhaps there's more at play here than what the government is trying to tell the public.

The government, as you know, has a couple of arguments. One is that it's inconsistent for pharmacists to be selling cigarettes at the front of the store and health products at the back of the store. Second, perhaps—

they're not sure; they have no proof—it will reduce consumption by young people if we can restrict the number of access points to purchase cigarettes, ie, get rid of the sales in pharmacies.

I don't buy either argument. As a young person I didn't see pharmacies as a health thing. I saw it as a place where I got supplies for my science project or I picked up the odd prescription for my parents. That was the only time I went to a pharmacy, probably, until I was in my latter teens. The young people we've had before this committee, many of them don't buy their cigarettes at pharmacies. In fact, one this morning said actually the only place that ever checked for ID was Shoppers Drug Mart.

Do you think there's something else at play here? Do you have any thoughts as to why the government's trying to put you out of business?

**Mr George Phillips:** Like I said in my presentation here, I don't think the government is well informed. I think they've been misinformed. To begin with, the government calls this a health care facility. A pharmacy is in no way a health care facility. A pharmacy is a retail operation. We retail drugs. Your prescription drugs we sell to you on retail.

**Mr Jim Wilson:** Exactly. The formulary dictates that.

**Mr George Phillips:** I am a professional, because to work in a pharmacy or to be a pharmacist I need a degree. That makes me a professional. But a pharmacy is not a health care facility. A hospital is a health care facility. A health clinic is a health care facility. I believe that the government is thinking, in its contracted view, that any pharmacy is a health care facility. It made them come up with this kind of argument. A pharmacy is a retail operation. We can't exist on just selling prescriptions, which is what our major function is.

Some pharmacies, on the other hand, that are located in huge medical buildings do not need to do that to have a reasonable bottom line. They don't need to sell other things. I sell panty hose, I sell hair products, hair colour, everything. I sell condoms.

If the government were well informed, it would have known, the people who are sponsoring this bill would have known, that we counsel people against cigarette smoking. We are the only place where you can come in and the pharmacist can sit with you and counsel you about the ills of cigarette smoking.

At the beginning, I thought it was a conspiracy against pharmacies. The timing is so bad, coming at the heels of the social contract and a reduction in our fee. I figured it was a double whammy and somebody really hates us up there. I see no reason whatsoever. Look at how unfair this is, Mr Wilson.

**Mr Jim Wilson:** I agree with you. I've been putting forward the conspiracy theory, but you're the only one confirming it to date. I appreciate your comments because we used to have a deputy minister who said there were too many pharmacists.

**The Chair:** Mr Wilson, we're tight on time. Mr McGuinty, a short final question, please.

**Mr McGuinty:** Mr Phillips, I want to thank you and,

in fact, since time didn't permit, I'll profit from the occasion to thank Ms Braden and Mr Lackie for what I thought were thoughtful and moderate statements regarding the implication that this bill will have on your businesses.

I'm not sure if I can accept that pharmacists can both counsel against the use of tobacco and sell it at the same time. I'm not sure that I can accept that because we just haven't had enough conclusive evidence that pharmacists are more responsible in terms of how they sell tobacco and that they're more careful in terms of not selling it to people under 19.

One thing I do agree with you completely on, and with your colleagues who spoke earlier this afternoon, is that I find it unfair to impose a tobacco ban on pharmacies alone. It's my understanding that your total sales for the industry average are from 7% to 8% for tobacco sales, and the argument is made that you could make this up elsewhere if there was a ban put into effect. I also understand that you wouldn't make it up through additional prescriptions; you're not going to have more people getting more sick as a result of a tobacco ban.

1520

My question to you is, if the government is sure that you won't suffer any losses, or if you do, that you'll be able to make them up elsewhere, why don't we ban tobacco sales by any retailer who's selling tobacco in the range of 7% to 8%, because surely they could make it up elsewhere in the store?

**Mr George Phillips:** No, no, tobacco sales are 7%. You buy tobacco; the profit margin is very low. It's a convenience item. I've been a pharmacist for 22 years. I know of people who would come to my pharmacy to buy their prescription—which is my livelihood, by the way—when tobacco is on sale, when cigarettes are on sale. When the person is in the pharmacy to pick up their tobacco, he would go around and pick up some hair gel. My bottom line there is 30%. He might pick up some pop. He might pick up some aspirin. He might come to the pharmacist for a question. Anything like that. Seven per cent is nothing, but the sales that are generated by the person's presence in my pharmacy are what's important to me, not the tobacco.

You talk about unfairness. Yes, it's unfair for the government of Ontario to ban cigarettes only in pharmacies. What are you going to achieve?

**Mr McGuinty:** Good question.

**Mr George Phillips:** They were going to buy it. Take a grocery store with a deli, a bakery, groceries, a pharmacy in the corner, a place where they sell sandwiches. What are you going to tell these people? Are you going to tell these people, "You're a health care facility"? Are you going to tell a grocer: "You're a health care facility. You can't sell cigarettes here"? The public will be greatly inconvenienced. They come to buy their groceries. Convenience is the order of the day.

You've been told that the three principles in business are location, location, location. Add to that convenience, convenience, convenience. I don't want to go to two places if I go out in today's weather, for instance. I want



to go buy my cigarettes and get my other allied purchases at the same place. It's very unfair, not only to pharmacists but also to the general public.

**The Chair:** Thank you very much, Mr Phillips, for coming before the committee today.

HALIBURTON, KAWARTHA, PINE RIDGE  
DISTRICT HEALTH UNIT

**Mr Bill Wensley:** I'm Bill Wensley, the vice-chair of the board of the Haliburton, Kawartha, Pine Ridge District Health Unit. We provide public health services in home care to the people of Haliburton, Victoria and Northumberland counties. Our medical officer of health, Dr Hukowich, isn't able to be here today. Actually, we flipped a coin. One of us was going to come on the train and the other was going to drive, and Via Rail won out.

I think it would be important for me to state my bias at the outset. I'm a former smoker, I'm the retired registrar of the Ontario College of Pharmacists and I'm a strong advocate of wellness promotion and illness prevention, as I'm sure everyone else here is.

I also want to congratulate the committee and yourself, Mr Chairman, for your remarkable perseverance and patience over the past couple of weeks. I too have watched these proceedings on cable television, the first time I've ever done it. It's at times a painful process but I'm sure it's worthwhile.

Our board and the staff of our health unit wish to indicate our strong support for Bill 119. We endorse the intent to further restrict access to tobacco by youngsters and support efforts to create a more coherent public message as to the place that tobacco should occupy in our society.

The detrimental effects of tobacco use have been clearly demonstrated. There is no argument as to the significant level of harmful effect from tobacco use except from those few having a monetary interest in being able to profit through the continued unrestricted sale of tobacco. Their voices, no matter how loud, must not be allowed to prevail over the clear and coherent message from the health care community.

Tobacco is a unique product in that it kills and sickens such a high proportion of its users when used specifically as intended. I think this is the main theme of our presentation. It is a product where initiation occurs during childhood and adolescence, and continued use during adulthood is more a function of the addictive nature of nicotine rather than a personal and informed choice.

Its continued availability is an accident of history. As we know, it was introduced into society at a time when its harmful effects were unknown. We know of no other slowly acting addictive poison, yet is it available openly on every street corner. While it remains a legal product because of society's general acceptance of the argument that prohibition would not succeed in its elimination, is tobacco a truly legitimate product?

Is there anyone, apart from those who directly profit from the production and sale of tobacco, who wants to see a higher proportion of smokers? Do smokers themselves want to see their children or grandchildren start smoking? Would we allow physicians and nurses to

promote tobacco use? Would the College of Physicians and Surgeons or the government not intervene if physicians began selling tobacco from their waiting rooms?

Yet some would still argue the right of pharmacists to sell tobacco products. They claim that pharmacists are retail business persons who have a right to sell a legal product. This argument totally ignores the fact that pharmacists are not simply retail business persons but are health care professionals. They are granted a monopoly for the sale of non-prescription drugs and the dispensing of medications as prescribed by physicians. Their ability to sell tobacco adds a needless legitimacy to what is otherwise a uniquely harmful substance. It serves to confuse our children. It fosters a belief that tobacco is not as harmful as is claimed, since we freely allow its sale from facilities whose primary purpose relates to health care.

I can remember when I was a 13-year-old starting to smoke. Some people would tell me: "It's not good for you. Don't do it." I would use the argument, "Well, it's got to be okay because doctors smoke." Now we realize, of course, that very few physicians do smoke. I think we've come a long way since that day. The point I want to make here is that every possible step should be taken to eliminate public images that tobacco use is safe.

We go on to pose some perhaps rhetorical questions. I'll cite these. Failure to act on this proposed legislation would only be explainable on the basis that the Legislature collectively, and you its members individually, believed that (1) there was no problem or only a minimal problem associated with tobacco use; (2) the benefit to society and to individual members of continued tobacco use outweighed the level of harm; (3) sufficient steps had already been taken that would, in time, eliminate the tobacco problem; (4) the steps proposed in this legislation would not achieve the desired effect; or (5) the problem of tobacco use was an individual problem or choice and not one for the government to solve.

I'm going to briefly develop each of these points. First, we know the committee has been provided with scientific evidence that has conclusively shown the causal relationship between tobacco use and such health problems as chronic bronchitis, emphysema, lung cancer and heart disease.

What could be the claimed benefits from children starting to smoke? Most adults would like to quit but find it difficult, if not impossible. The benefit for most smokers is solely the avoidance of the signs and symptoms of nicotine withdrawal rather than any positive effect from tobacco use. Does the revenue to government through taxation outweigh the added health care and other costs created by tobacco use? I think not.

Twenty per cent of our adolescents still become smokers. How many generations are we prepared to wait to see a further reduction in tobacco use?

1530

What about the effect of this legislation? Clearly the tobacco industry sees the potential of these measures curtailing their sales or they would not be concerned by the passage of this legislation. They are certainly the most expert at understanding the role of tobacco and its



merchandising. Their fear that these measures will have an impact on their profits is a good sign of the efficacy of this legislation if passed.

Objection to tobacco use by health professionals is not an issue of morality; it is an issue of causing ill health and premature death. Tobacco use is not a personal, informed choice made by adults. Tobacco initiation is a deliberate addiction of our children, a vulnerable group in society who have the right to expect protection. In what other way does a free and democratic society allow a group of adults to prey on children? Is it not the responsibility of all of us, including government, to protect children?

During the course of your deliberations, you have already seen and will continue to see delegations of two particular types. On the one side will be individuals who wish to put an end to this unnecessary epidemic of ill health and premature death caused by tobacco use. On the other side are those from the tobacco industry with dollar signs in their eyes whose bank account size is directly related to their continued ability to ensure a market with each coming generation of unsuspecting children.

While this piece of legislation is undoubtedly not the final answer to the problem of tobacco use, it is a necessary and important step on the road leading to a healthier society. Your support should be, and I am convinced will be, with those whose vested interests lie with the health of our citizens.

We strongly endorse this bill, recognizing that it is one more step in a long journey.

**Mrs Haslam:** I get so angry when I hear people paint the government as if we have this grudge to bear on small business people or on the pharmacists, as if we're picking on the pharmacists because we're asking them to be a health practitioner, because we're doing what the Ontario College of Pharmacists has asked us to do. It just makes my blood boil.

I look at the costs involved in the health budget, I look at the costs involved with tobacco and the loss of job time, I look at the number of people who die, and I ask myself, if I were a health practitioner, if I were a pharmacist and I took an oath to promote the health of people in Ontario, I think those standards that I should be operating under and the responsibility that I would have as a health practitioner would be something I would hold very dear to me. I believe in principles.

It really angers me when I think that we're being painted as if it's all our fault. We're asking them to do something that they've been asked to do for years voluntarily by the Ontario College of Pharmacists. Excuse me for venting. I don't vent too often, Mr Chair. I just want to vent this time.

I'm glad you support this. To tell you the truth, a majority of the people who come in do support what we're trying to do in this legislation. It's interesting to see that they want us to go further, and I keep asking, is this the time? Can we now bring in a tobacco control board? Is this the time to put a whole process of licensing in place instead of going with what has already been suggested? I'm sure that the people in the ministry will

say, "Oh, no, no, no, Karen, please don't ask about licensing," but I've never been known to follow bureaucrats' advice in the first place.

When I was associate minister of Health, we had presentations come in and a lot of people said, "We would like the licensing." The concern seemed to be that we didn't want to set up a whole new process, a whole new layer. Do you feel that we should go that extra step, that we should look at licensing, if what we're seeing in the model that is in the legislation is saying, "We can do the same thing by bringing it in in this model as a statutory ticketing," where they do lose it, they can't even have it on their premises.

Most people come in and say, "If they lose their licence, they'll really be worried," but on the other hand, if they lose the right to sell tobacco, they can't even have it on their premises. It must be removed. We send a letter to the manufacturers.

**The Chair:** Mrs Haslam, are you going to ask a question?

**Mrs Haslam:** Is that not as effective as licensing?

**Mr Wensley:** Just to answer your question about the efficacy of a licensed-vendor approach, I think that's probably a very effective way to do it. It's been said here before that the licensed vendor would have a very strong interest in seeing that his or her licence was not revoked for cause. It would tend to be somewhat self-policing. So I think down the road the idea of licensing vendors is a very good one.

I wonder, however, if we're quite ready for that or if we can handle it. I'm not arguing against it, but I'm a firm believer in a course of limited objectives. As I said, we believe that this bill is one step forward towards that end. I believe that if we can reduce the number of retail outlets, somehow control them and have them licensed and have a very strong reason for them not to stray from the conditions of that licence, we will also be further down that road.

**The Chair:** Thank you. I regret that time is our enemy this afternoon, but I want to thank you very much for coming before the committee.

#### PSYCHIATRIC PATIENT ADVOCATE OFFICE

**Mr David Giuffrida:** Good afternoon. My name is David Giuffrida. I'm the acting director of the Psychiatric Patient Advocate Office. Joining me today is Duff Waring. Mr Waring has served as the systemic policy adviser to our program for several years and is currently our acting legal counsel. We'd both like to present our submission to you today.

**Mr Duff Waring:** The Psychiatric Patient Advocate Office works for the rights of patients in Ontario's 10 provincial psychiatric hospitals. We are a quasi-independent program of the Ministry of Health, but we do not speak on behalf of the ministry. We speak on behalf of the patients who are often our clients.

I'd like to point out before we get into our submission that we are not promoting an outright opposition to this bill. We are challenging its unintended disparate impact on patients in psychiatric facilities.

I'm sure you're aware that people with psychiatric labels are often denied the right to make decisions about their lives that other Ontarians take for granted. In fact the Ontario Mental Health Act reflects the reality that even patients who are involuntarily detained in psychiatric facilities can be as competent as any other Ontarian to make decisions about their treatment, finances or lifestyle.

We uphold the right of psychiatric patients to make the same choices that other Ontarians are entitled to make. Consequently, we promote the right of psychiatric patients to choose whether to smoke where they live. We also assert that psychiatric patients should be able to buy tobacco near where they live. Bill 119 could deny vulnerable Ontarians in care facilities the right to make these choices.

The fact is that the majority of inpatients or outpatients smoke. They have identified smoking as one of their few pleasures and would not choose to reside in or attend a facility in which they could not smoke. The two petitions from patients at the St Thomas and Penetanguishene psychiatric hospitals that we have included in our submission illustrate this point. These patients oppose further restrictions on the use and sale of tobacco in psychiatric facilities, and we support them.

Bill 119 designates places in which smoking would be prohibited and refers to psychiatric facilities and other residential settings in which care is provided, such as nursing homes and homes for special care. We are pleased that section 9, paragraph 1, of this bill would allow exceptions for designated smoking areas that are exempted by regulation. This section would allow the maintenance of the designated smoking areas currently in place in psychiatric facilities.

We note also that the Ontario public service policy for a smoke-free workplace in psychiatric hospitals also allows for designated smoking areas. The rationale behind this aspect of the OPS policy is that the hospital is, however temporarily, the patient's place of residence and that denying tobacco to patients who smoke can exacerbate their clinical condition.

#### 1540

We observe that many clinicians have complained about outpatients who are asked to attend hospital on a daily basis but who are non-compliant with medication and other therapeutic programs. These clinicians are currently trying to improve upon and expand such community-based day programs for patients who have been discharged from the hospital. We suggest that further restrictions on smoking would frustrate this effort. They would make psychiatric facilities inhospitable to the majority of outpatients who smoke. This would obviously interfere with their willingness to attend the hospital and comply with treatment.

Apparently the initial opposition to smoking restrictions in care facilities has not faded. The Clarke Institute of Psychiatry, for instance, initially banned smoking altogether. It now maintains designated smoking areas on inpatient wards. This reversal in hospital policy was apparently in response to strong protests by the patients,

and staff concerns about the fire hazard from surreptitious smoking.

We do not dispute the negative health effects attributed to smoking. We recognize the enormous health care costs and lost productivity resulting from smoking.

We also recognize that adult Ontarians are still allowed to smoke in their own homes and legally purchase tobacco near their homes. Bill 119 will not affect these Ontarians the same way it will affect or could affect our clients. We feel that our laws should apply equally to Ontarians who live in psychiatric hospitals.

Bill 119 disproportionately affects people who call an institution a home because it prohibits the sale of tobacco in these facilities. If we wish to allow residents in these facilities the same right to smoke where they live that other Ontarians have, is it not cynical to make tobacco inaccessible to them?

**Mr Giuffrida:** I'd like to underscore the point Mr Waring has made about the risk of making psychiatric facilities less hospitable to their intended beneficiaries. Clinicians tell us that it can be difficult to motivate people with major mental illnesses to come to day treatment programs and to take medication.

I have in front of me a draft document that one psychiatric hospital is considering using if it's obliged to enforce current and proposed laws restricting smoking. It would be handed to a patient caught smoking in the wrong place. It says: "If you are observed smoking in a non-smoking area, security is authorized to ask you to put it out. If you refuse to put it out, security has the authority to escort you from the area to the outside." Then in bold face, "If you receive three of these notices, you will be banned from the hospital for one week." So we find health care facilities driven to a point where they may consider having to drive the patients they're trying to serve off the grounds in order to enforce restrictive smoking laws.

One of the ways of measuring whether a system is fair is whether it treats like cases alike. There is a purity to Bill 119 in that, if the paradigm you use is that everyone in a health facility will be equally exposed to this law and no one in a health facility will be able to smoke, that seems consistent, but I'm going to invite you to categorize things differently.

As Mr Waring pointed out, most Ontarians continue to be permitted to smoke in their homes. The state of evolution of our thinking in this social policy area has not yet extended to the point where we have outright banned the use of tobacco. So to extend a consistent right to psychiatric patients, they should be allowed to smoke where they reside as well.

Another way to categorize it is situations in which the state detains people and provides their housing. This happens in health care facilities when people may be detained under the Mental Health Act and under the Criminal Code. It also happens in correctional facilities, and there is not the same application of the bill to correctional facilities. There are about 7,800 inmates at any one time in Ontario's correctional facilities, and nothing in Bill 119 is going to restrict their ability to



purchase tobacco in those settings. So we're concerned about the disparate impact.

What we'd recommend is that a power be placed in the legislation that would permit the making of regulations which would permit the limited sale of tobacco products to adults who are residing in care facilities.

Our other recommendation deals with the section of the legislation that allows other legislation, in particular municipal bylaws that are more restrictive of smoking, to override Bill 119.

Our concern is that if the Legislature on the provincial level decides to honour the right of Ontarians to smoke where they live, it would be unfair to oblige them to make this argument at over 800 municipalities, if you will, across Ontario. If the policy is established in this legislation, then it would be unfortunate if municipal bylaws, for example, could be more restrictive and could ban smoking on the psych ward of a hospital where the hospital has succeeded in getting a regulation under Bill 119 permitting smoking.

Those are our two concerns. The sale of tobacco should be allowed in places where people live, particularly where they are detained. Where the state has said, "You can't leave these premises," you have a right to smoke. It's not fair to say, "But you can't purchase tobacco." Human ingenuity being what it is, in places where the sale of tobacco is restricted now, it has been our understanding that health care staff are often obliging in helping patients procure tobacco from outside the hospital grounds, and I don't know if they're particularly dedicated to buying retail. At least if it were in the hospital you'd be collecting taxes on it. We'll pause there for questions.

**The Chair:** Thank you. This is the first time we've really had this issue raised, so I'm going to give each caucus an opportunity to raise a question and I'd just ask a little cooperation in perhaps not too long.

**Mr Jim Wilson:** David, good to see you again, and Duff. As usual, you bring a thoughtful presentation before the standing committee. The issue was kind of raised before with respect to veterans in Sunnybrook. The suggestion, and I thought it was rather astonishing, is apparently that when their tuck shop is closed now on weekends, people come in and sell the veterans contraband cigarettes at premium prices. Is that going on or could that go on in psychiatric institutions? You're more of a restrictive institution, but you just mentioned that staff sometimes help patients procure cigarettes. If you can't buy them legally, what will happen?

**Mr Giuffrida:** It has never been suggested to me that the staff are making any profit when they assist patients—

**Mr Jim Wilson:** No, I assume the staff are doing it as a favour.

**Mr Giuffrida:** Yes. But yes, it is our understanding that staff are accommodating patients in that way.

**Mr Jim Wilson:** The legion told us that in the case of veterans, it's not the staff but other people coming in off the street and selling the veterans contraband cigarettes.

**Mr Giuffrida:** I haven't been informed of that

happening, but tobacco may still be sold in a number of the provincial psychiatric hospitals. We don't perhaps have a wide enough sample to see if that would happen.

**Mr Jim Wilson:** The bottom line is, you'd just like the status quo with respect to psychiatric hospitals?

**Mr Giuffrida:** Well, the status quo permits the sale of tobacco products to anyone of appropriate age; currently visitors, staff as well as patients. To be consistent with the policy objectives of this legislation, you might want to restrict the sale of tobacco products in psychiatric hospitals so it's not available to staff and visitors. They have the ability to leave the grounds and buy it elsewhere. But it should be made available to people who cannot leave the grounds.

**Mr McGuinty:** Thank you very much, gentlemen, for highlighting what I think is quite rightly categorized as a discriminatory provision in Bill 119.

Somebody visited my constituency office in Ottawa recently and described for me the importance of maintaining a routine for some of the inpatients at a psychiatric facility. In effect, I interpret this as meaning that we could make a very good argument to the effect that it is in a person's overall health picture to be able to continue to smoke at a facility. Would you agree with that?

**Mr Giuffrida:** I'm sorry, could you say that once more, please?

**Mr McGuinty:** It is in that person's interests, I guess from a global health perspective, that they be able to continue to smoke.

**Mr Giuffrida:** I think we ground it in rights rather than health. They have the same right as other Ontarians have to make decisions, whether that includes overeating, whether that includes smoking.

**Mr Waring:** I think it's fair to say that some of our clients have said to us that they're better able to maintain their own psychological wellbeing if they can smoke. That's, I think, as far as we could take that.

**Mr McGuinty:** I was thinking of stress management.

**Mr Giuffrida:** The point is particularly applicable within the first couple of days after admission, when a person may be in psychiatric crisis. If, as a consequence of admission, they are totally denied access to tobacco, that is arguably the worst time to oblige somebody to go through nicotine withdrawal.

**Mr Waring:** I'd suggest to you that you could find many staff people in the provincial psychiatric hospitals who would agree with Mr Giuffrida on that.

**Mr O'Connor:** I guess at this point I'd just like to thank you for coming. You certainly put a different light into an area that we have had limited discussion on.

Maybe you could enlighten me a wee bit: Given that, of course, you're advocating for the rights of the patients, I guess that puts you in a bit of a predicament when you would then have to find protection for the same non-smokers in respect to the accommodation of their wishes as well. I can see there are some dilemmas in even being an advocate for two sides of an issue.

If you want to comment on that, I'd appreciate it. I thank you for coming before the committee and sharing



the thoughts of those you advocate for.

**Mr Waring:** I think over the years we've been consistent in our position here. We respect, as much as possible, the rights of non-smokers and we try and respect the rights of our clients who do smoke, which is why we have always supported designated smoking areas in the psychiatric hospitals.

**Mr Giuffrida:** The hospitals have already invested some money in ensuring that these smoking areas are separately ventilated so the status quo substantially accommodates the rights of smokers and non-smokers.

**The Chair:** Thank you very much for coming before the committee today and for your written presentation. We appreciate it.

1550

#### KOHL AND FRISCH LTD

**Mr Ronald Frisch:** Thank you for the opportunity to present my company's views with respect to Bill 119.

My name is Ronald Frisch and I am chief executive officer of Kohl and Frisch Ltd, a privately held family business that has operated as a wholesale distributor in the province of Ontario for over 75 years. Since 1916 we have serviced a customer base that includes drugstores, both chains and independents, convenience stores, discount chains and department stores.

The bulk of our business is with drugstores and in that regard we service stores throughout the province with anything they may choose from our product line which includes pharmaceuticals, health and beauty aids, tobacco, confectionery, general sundries and any other items that our customers may sell at any particular point in time. Our business is service and if our customers, and therefore the consumers, create a demand for a product, we will distribute it for them as part of our commitment to handle all of their product needs.

I have read Bill 119 and am fully supportive of some of the measures that have been proposed. I do, however, have some concerns that I would like to address, as follows:

First, the requirement for wholesale reports: Section 8 indicates the requirement on the part of wholesale distributors to provide reports to the Ministry of Health in accordance with the regulations. Bill 119 does not give any indication of what these regulations are. As wholesale distributors who do not sell to the public, our company and most other wholesale distributors in Ontario only sell to retailers who have provided us with their Ontario retail sales tax vendor permit. The Ministry of Revenue already receives reports from us on the tobacco portion of our business. In the current economic environment, we are not looking to increase expenses by producing more reports that don't help us run our business. If there is a justifiable need, would the wholesale distributors of Ontario be compensated for the administrative function that seems to be asked of us?

Conversely, I do note that subsection 14(4) mentions that a fine could be levied against a distributor for failing to comply with the reporting requirement in its prescribed format, a format which is not identified in the bill. This fine could be as much as \$100,000. This seems to

indicate that an error on a backup administrative function, where no physical product is involved, could result in a fine of immense proportions and threaten the very foundation of a business. Surely this cannot be the intent. I can assure you that no fine is needed to ensure that wholesale distributors comply with the law and I would respectfully request that this entire area be rethought.

Second, the change in age to purchase tobacco from 18 to 19: I wholeheartedly applaud this change but I would suggest that teenagers be required to show proof of age when making a purchase. The onus should not fall solely on the retailer. A retailer can be enticed into selling to those under the legal age, or an employee of a retailer can simply make a mistake. It's harder if the teenager produces his proof of age as a matter of course. Teenagers know that they have to produce cash or a credit card to make a purchase. They also know that they have to have their birth certificate or passport in order to travel outside the country. They should share the responsibility of ensuring that tobacco is only purchased by those of legal age.

My interest here is not completely an unselfish one. I don't wish to hear a customer of mine tell me that he can't pay for the merchandise he bought on credit because he has to pay his fine for selling tobacco to someone underage and he has no further funds. This can and will happen.

As an aside, we should all realize that this age restriction only applies to purchases in legal retail outlets. The illegal black market in smuggled cigarettes has no legal age. This is where the greatest risk lies. While I'm aware that the Lindquist Avey report that has been presented to you indicates that just over 25% of the Ontario market is illegal, I believe they are being conservative.

I can tell you that our sales of tobacco products have declined by almost 50% in the last two years alone. It's no wonder; the illegal cigarettes are being sold at prices that equate to the legal prices in 1987. Until the illegal market is stamped out, tobacco will be readily accessible to anyone of any age within the province.

The third area of concern is the ban on selling tobacco in drugstores. I believe that such a ban will have a major economic impact on drugstores and, by translation, on companies like mine who supply them. Please consider the following areas of concern:

First, cash flow for the store: Since the drugstores do not sell on credit but they do make their purchases on credit, the stores use the cash flow generated—which is roughly over \$40 per carton and this is substantial—to supplement their banking positions by thousands of dollars.

I can tell you that today many independent drugstores have trouble paying their bills on time. In almost every case they complain about the long delay in getting paid by the provincial government for Ontario drug benefit claims. These delays range from between two and six months.

With this as a starting point, if the cash flow from tobacco sales disappears, these stores will find it even tougher to operate and many won't survive. I don't think

the banks will be extending more credit to single-location retail stores who are already strapped financially.

After all, their government revenues have been cut back, their product line will have been reduced and all the while with the bank's security reduced as a result of the new bankruptcy laws of December 1992, which allocate the inventory on hand back to the creditor instead of to the secured bank.

Second, impulse sales: Despite the reduction in the number of smokers over the years, we must realize that a substantial number of people still smoke. When people wishing to purchase tobacco walk into a retail store, the retailer is hoping to sell them more than just tobacco. For over 75 years, for example, we have observed the strong link between our customers' purchases of confectionery and tobacco.

Internally, we have been mindful of efficiencies tailored to delivering tobacco and confectionery at the same time. It is our belief that if tobacco were to be unavailable in drugstores, the confectionery and some other product sales would plummet in these stores as well and would be purchased in many cases wherever the tobacco is purchased.

As many of these items generate good profits, the drugstore operator would again have to find a way to overcome this issue. I am not surprised that the Coopers and Lybrand report that has been presented to you confirms my personal observation in this regard.

How does this proposed ban impact on my company? First, wholesalers will be faced with more difficult credit and collection tasks than exist today and there will be inevitable losses to be covered. As well, bearing in mind that as a wholesale distributor we deliver a mixed bag of products to the drugstore, we have certain other costs that must be covered, including the cost of running our building and getting the truck to the store.

The object for us as business people, of course, is to generate more profit on each delivery than the cost incurred. While the profit margin on tobacco is quite small, it still contributes to the overall funds needed to service the customer. If, for example, it costs us \$100 to make that delivery, and currently \$20 is covered through the profit on the tobacco portion of the order, we will have to cover that extra \$20 either by raising prices or by cutting costs or services.

As our current services include delivering pharmaceuticals, even one single bottle, to drugstores within three to five hours of receiving the order within the Golden Horseshoe and within 18 hours for the rest of Ontario, such services play an unsung but essential part in the delivery of health care in Ontario. It would be a step backward to tamper with such services, yet the alternative would be to raise prices which would increase the cost of health care in Ontario. Neither of these alternatives would be desirable, yet they may be unavoidable.

**1600**

What must be recognized is that while certain drugstores are prescription dispensaries only, others are full-service retail stores that include a dispensary. We have recognized this factor in the way we deal with the stores.

First, we send out two separate catalogues, one for the front shop, which is like this one and lists thousands of products from shampoos to batteries and all kinds of front-shop merchandise within the store. Typically, the front-store manager receives this catalogue. The other catalogue lists pharmaceuticals only, and this catalogue is sent to the professional pharmacist in the store, who uses it in terms of maintaining his inventory and placing his orders.

Then we receive the store's orders separately by phone. The pharmacist phones the pharmaceutical orders to one of our dedicated sales personnel who only take pharmaceutical orders. The front-shop order is placed by different store personnel, calling different sales people within our office. It really is like there are two stores within the same four walls at the retail location. We have recognized this in our business, and I believe that you should recognize it in the proposed legislation by allowing the continued sale of tobacco in these retail environments.

I am aware that certain drugstores in Ontario have voluntarily stopped selling tobacco and have been able to continue along in business. Of our customers, only a few have taken this approach, and in each case it was to their economic advantage to do so. Each retail drugstore should similarly be able to evaluate its own business and decide if it can survive the change to its economic position that would result.

Let's not forget that we're talking about a legal product and that the retailer must compete with other stores for the consumer's dollar. Let's also remember that the retailer has to pay the rent and the bank. If he can't, there won't be any ethics or messages to even talk about.

I have to tell you that I find it interesting that on the way here I heard the Treasurer being interviewed on the radio about today's federal tobacco initiative. He said he could not afford to do without his revenue from tobacco. I think the drugstores' position, in many cases, is very similar.

A drugstore today is more than just a dispensary of prescriptions. It is a marketplace for health and beauty aids, household products, groceries, confectionery and tobacco as well. In fact, the term "drugstore" may be a misnomer. It is more like a general store with a dispensary, and the pharmacist has very little or nothing to do with some of the products that may be available in the store, because his or her domain seems to be the dispensary only. At the very least, I would recommend that the government conduct an economic impact study to determine the effect of a ban on the sale of tobacco in drugstores.

I sincerely hope that you will consider these various issues I have raised. I thank you again for the opportunity to present my company's views on these matters.

**Mrs Haslam:** Actually, I liked your comment on page 5: "The term 'drugstore' may be a misnomer." I think you're right. I think we should call it a "supercosmetic mart" or just "supermart" and leave the drug out of it, and maybe we wouldn't have the arguments we seem to be having over the sale of tobacco in a drugstore.

You mentioned the Coopers and Lybrand report. Have



you read the Coopers and Lybrand report?

**Mr Frisch:** I have not read it. I'm aware of some of the information.

**Mrs Haslam:** Are you aware that out of 1,400 pharmacists, they interviewed 13?

**Mr Frisch:** No.

**Mrs Haslam:** You sell to pharmacies that don't sell tobacco?

**Mr Frisch:** Yes.

**Mrs Haslam:** What products replaced the tobacco then? You do sell to pharmacies that don't sell tobacco. It's not a major percentage of your business?

**Mr Frisch:** No. Within the drugstore market that we service, some of them are dispensaries only that have never sold tobacco, and therefore it's not an issue. The few that I know of that did stop selling tobacco, they were not purchasing, at least not from us. They may have purchased from other wholesalers, I don't know, but their purchases from us were very minimal, and I think that probably economically they did not suffer and possibly replaced it with another line of product that countered it.

**Mrs Haslam:** Do you offer discounts for other products based on the amount of tobacco you market?

**Mr Frisch:** No, we don't.

**Mr Jim Wilson:** I think you make a very good argument, and it would be an argument that would hold water if you were talking to legislators who all understood retail and all understood business.

It seems to me that there are a lot of people out there who have a lot of nerve coming before this committee wanting to put somebody out of business and have never run a business in their lives.

I think the government misses the point, and you've made it again, and Mr Phillips, who's a Pharma Plus pharmacist and was in just within the hour, saying, "Look, it's not, in the case of the pharmacist, the profit necessarily on tobacco products; it's the traffic flow of the customers coming in and picking up all the other products they may pick up while they're in the store." That's the point, and that's the point that I think is missed.

Secondly, it seems to me that the government talks out of both sides of its mouth. It is very clear in the Ministry of Health—I've been Health critic for almost three years now—that during negotiations with the ODB pricing, the government makes it very clear that they expect pharmacists to make money at the retail end of the store.

In essence, because the government gives pharmacists a monopoly on selling drugs, they don't expect the pharmacist to make money at the back of the store. Therefore, you have to make your profit to pay all of the expenses you mentioned at the front of the store, and part of that retailing and marketing is the customer flow that comes with the sale of tobacco products.

It's pretty simple to me. I don't know why it's so convoluted for people, but we've been through this before. It's déjà vu all over again. We did the same thing on labour laws, and we will repeal those.

You mentioned as your very first point whether you're

going to be compensated for yet another report that has to be filled out. The small business people at lunch told me, for example, with—and I just did some off the top of my head: PST, GST, EHT, employer health tax, T4 preps, WCB, UI, Statistics Canada. The list goes on to almost 24 that I could think of, because my family was in retail for a number of years.

I added up the reporting dates that we would go through. We would have 35 reporting dates for all of those things during the year; you know, GST quarterly, WCB quarterly. We used to just put all the cheques in one envelope, send it in and hope to God the bureaucrats didn't lose the cheques—and huge fines if we missed any of those bloody reporting dates. Now here's another one.

But I think the problem is, and I want you to comment on this, the Ministry of Health doesn't talk to the treasury, other than the treasury says: "We need the \$800 million from tobacco sales, so don't take it out of all retailers. But if you want to pick on pharmacists, we know that'll have no effect on our revenues because it won't reduce consumption of cigarettes. So go ahead and do that." The Treasurer again today is confirming that, but yet again another cost of doing business with another report.

There is precedent in the reporting system to rebate retailers for some of the forms they fill out. What are your thoughts on this? I don't know how you explain any better than you did in your presentation, but we'll give you another opportunity to try and explain to people what the net effect of all these rules and regulations is on business.

**Mr Frisch:** Well, we're trying to be efficient, and the more efficient we can be, the lower we can keep our prices. That translates all through the economy. The more overhead that's put on it at the business level, the more reports, especially with stiff fines, you have to create the internal administrative function to make sure that you're not susceptible to these.

Any cost that's incurred, a fine has to be passed on or absorbed in some way. In a low-margin business like the wholesale business, and I think you've heard that from other presenters, I can't imagine that wholesalers can absorb hefty fines when we're working so close to the line and trying to provide the kind of services.

As I indicated, we can get pharmaceuticals ordered by a store at noon delivered to a store at 3 o'clock. That's what we want to focus on, not the back end of reporting, when we don't even know what the report is going to be used for and we're already giving certain reports.

**Mr Jim Wilson:** The Ministry of Revenue already gets reports from you.

**Mr Frisch:** Yes, monthly.

**Mr Jim Wilson:** Should it be your problem that this report isn't sufficient for the Ministry of Health?

**Mr Frisch:** No, I don't think it should be. We're already complying.

**Mr Jim Wilson:** So you just have another ministry in isolation asking you for another report, and I'll bet not one bureaucrat in the Ministry of Health who's asking for this has ever run a small business. I'll bet that's where



it's coming from. It's just completely out of isolation.

**Mr Frisch:** Have they asked the Ministry of Revenue if their reports would satisfy the need?

**Mr Jim Wilson:** Apparently they have, and they don't, so they've decided on the new one. It's not like they're going to harmonize reports or anything. Maybe we can help you on that so you don't have to fill out two where the one would suffice.

**The Chair:** The parliamentary assistant would just like to make a clarification with respect to this issue of forms.

1610

**Mr O'Connor:** I appreciate your coming before us and talking about the wholesale reports and what not. As you may or may not know, there was a discussion document that was put out a year ago in January which was the draft or the proposed legislation that we're talking about here. The whole thing hinges on an overall strategy of how we're going to approach this. This is a comprehensive strategy to reduce tobacco use in the province of Ontario.

The forms that you've talked about that you fill out regarding the taxation—I appreciate that, and my colleague has talked about them—don't say where you've sold those cigarettes. It's a form and remission of the money; you're remitting the money. What it doesn't do for the Ministry of Health is say who's buying them and who's selling them, where they're sold, the type of product.

For us to deal with this in an overall strategy—because this is a health care strategy that the Ministry of Health is dealing with. That's why they pointed out a year ago in their document that this type of reporting is going to be very important, so that we can take a look at the end results that we want to achieve through the legislation.

I just wanted to explain that and hopefully give you an idea of why we want the reports. I guess you're going to be a partner in the health care of the future of the province of Ontario. Just as we've been applauded, you too can be applauded for the work that you do.

**The Chair:** Do you have any comment?

**Mr Frisch:** Yes, just to comment, we are already a partner in health care in Ontario through the work we do in delivering pharmaceuticals to drugstores throughout the province. I'm not aware of what the forms are, what information is required on the forms. I didn't see in Bill 119 that it would itemize it. But are you suggesting that we'll be submitting to you the names of our customers and who we sold to, invoice by invoice, date by date?

**Mr O'Connor:** No. It would be broader than that, and it will be dealt with in the regulations. The committee members are aware of this because we've tried to, where possible, indicate some of the regulations that would be affected. They're in their binder actually. If they take a look in their binder, the section dealing with the reporting, they'll note where we've tried to spell out why we have to put this reporting mechanism in there and the purpose of it. Of course, it's part of the overall tobacco strategy that the province is trying to put forward.

**Mr Frisch:** When they have a retail sales tax vendor permit number and the government has a record of that, they know, or can know, that the store is going to be selling the product tobacco, for example.

**Mr O'Connor:** Could.

**Mr Frisch:** Could know that they're going to be selling the product. If they already know, and you're not going to ask what they bought on a given day or how much they bought, what I'm saying is, if you have the information already, please don't ask us to increase our administrative burden to give you information that's already within the system.

**The Chair:** I think there is obviously going to be a lot more discussion around forms if this goes forward. I just think we've heard the views expressed, and at this point I'm going to have to bring it to a close. I'm sorry. But thank you very much for coming today before the committee.

JANE CHAMBERLIN

**Ms Jane Chamberlin:** I thank you for the opportunity to appear before you today. I'm here as a private citizen. I speak only for myself, but I think I should tell you that I served as a public member of the Ontario College of Pharmacists for six years and was the chairman of the college's task force on the sale of tobacco in pharmacies.

As you will know, the report of that committee adopted by the college in June 1991 asked that the government support the college in its request to remove tobacco sales from pharmacies in Ontario. Obviously I wholeheartedly support the intention of Bill 119, and specifically its initiative to remove the sale of tobacco from pharmacies.

In addition, I want to personally thank this government for introducing Bill 119, the opposition for supporting it and all parties for facilitating its progress in this committee.

As you have heard and are hearing at some length, the college task force heard from all sides every imaginable argument for and against restricting pharmacists from selling tobacco. I have some sympathy with the process that you're undergoing and, probably at 4:15, the fact that you're only barely awake, but I appreciate the opportunity to appear here.

**The Chair:** It's deceptive. We're really wide awake.

**Ms Chamberlin:** The response of the Ontario College of Pharmacists is on the record. Essentially, the college of pharmacists endorsed the need to "do the right thing." It recommended that health care professionals—and Ms Haslam brought this point up earlier, to my considerable gratification—should act in the best interests of their patients, even when that best interest could mean financial hardship to the professionals themselves. I think that's probably a fairly key point here. It's the crux of a number of the arguments that are being brought before you.

It was probably the most difficult decision ever made by the college. I felt the work of the Ontario College of Pharmacists showed courage and professional leadership. I'm proud of our efforts. But the college could not

implement its recommendations. To do so, we needed your help. Naturally, I am very grateful that you have endorsed our work and delighted that you have taken the next essential step. Believe me, when you put in that amount of effort, you're delighted to see some follow-through.

Also on the record are the very cogent and detailed arguments by the Ontario Campaign for Action on Tobacco about a number of proposed changes to various components of this bill. While I support these recommendations in general, I will use my brief time here to speak to one issue only, and that is what I see as the very essential provision to remove tobacco from pharmacies.

Please bear with me as I address some rather global issues. I think my points may add a new dimension to this debate.

Ontario's health system is publicly funded and comes with a very high pricetag. That's no news to anyone in this room. The public and its government in these tough economic times are quite rightly questioning whether they are receiving sufficient value for the money spent. I would suggest that when it comes to the cost of pharmacy services, we can get much better value.

A large percentage of the cost of educating pharmacists and of the cost of dispensing prescription drugs in Ontario is borne by the taxpayers of this province. These highly educated professionals, experts in the use of drugs and other health aids, are located on the main streets of virtually every town in this province. They are accessible to the public without appointment on every workday, all day, and often on Sundays and evenings as well. We have here a wonderful health care information resource. We pay for it. But we—and by “we” I mean the system and the public—badly underutilize this resource.

So what does it matter? You've only to look at hospitalization statistics and drug utilization studies to understand that this province is paying not only for the use of drugs, but for their misuse. For the elderly particularly, we incur high costs for hospital stays which are caused, not prevented, by the inappropriate use of drugs. A high percentage of misuse is based on misunderstanding.

There are enormous cost savings and huge benefits in quality of life to be gained from optimizing the use of the pharmacist as a public information resource, as a full contributor of the expertise we pay for for the health of Ontario citizens, to ensure the public's understanding of the correct use of drug products.

Now, tell me. If you were an average member of the public, would you seek and rely on health care advice from professionals who sold you a deadly product at the front of their establishments and then proffered a few elements of short-term symptom relief at the back? How would you respect a health care professional who was willing to profit from selling you tobacco?

Then again, if you were a teenager or perhaps someone who really did believe in the professional credibility of the pharmacist, would you not delude yourself, as Bill Wensley mentioned earlier, that perhaps if the product is endorsed for sale in a pharmacy, maybe it's really not all that bad?

The citizens of this province deserve better: both better service and better value for their money. The pharmacists of this province deserve better. They deserve the opportunity to contribute the full benefit of their professional expertise. Believe me, in many cases they are not. In many cases they are frustrated professionals because they have been very well trained and they in many cases sit at the back of the store and count, pour, lick and stick, which is hardly what we're paying for. They deserve the opportunity to fulfil their essential role as important members of the health care team.

**1620**

In closing, I ask you to endorse Bill 119. I would ask, indeed, particularly in the light of current federal initiatives—I wear black today—that you strengthen it. As the Ontario College of Pharmacists did in the report of its task force, I would suggest that you restrict the sale of tobacco to licensed outlets, as with the sale of liquor. This is the strongest approach and probably the only truly effective way to achieve the stated intentions of this bill, particularly to prevent the provision of tobacco to young persons. I believe the benefits of this approach will be clarified by others.

Bill 119 is a very important step on the road to a sane tobacco policy for this province. As Mr Wensley mentioned earlier, it is just one step but it is a very important one, hopefully an important step also to a healthier, tobacco-free society.

I welcome your questions and I offer my support. I'd be happy, if the opportunity arises, to help further on this very important health issue. Thank you for having me here today.

**Mrs Haslam:** On page 3, you mentioned the college could not implement the recommendations. I understand in chain drugstores sometimes pharmacists are hired to be in the back of the store, and that's their place within a chain store or in an A&P in particular. I understand that in a Shoppers Drug Mart, when the policy of their parent company, Imasco, is to sell tobacco, it's difficult for pharmacists to effectively have a voice in what products they sell. Is that some of the reasoning why it was difficult for the college to implement its recommendations, that you tried to do it in a volunteer way?

**Ms Chamberlin:** No. It was a difficult decision for the college to make. The college, on the best legal advice available, did not believe it had the power to implement the decisions. It needed the act to do that.

**Mrs Haslam:** Okay, that clarifies that for me. I always forget to thank people. I'd like to say thank you. This presentation needs to be framed. I am very impressed with the concise way you've come to the crux of the problem. I think you've been very straightforward and very, very clear on the situation as it now stands. I thank you for this presentation.

**Ms Chamberlin:** Thank you for your compliments.

**Mr Jim Wilson:** Ms Chamberlin, playing devil's advocate as I am over here, the sole devil sometimes on this side—

**Mrs Haslam:** Big devil.

**Mr Jim Wilson:** —I went through the RHPA with



pharmacists and everyone else in this room and very much, I think, understand the profession. It strikes me, as a legislator, that one of the reasons the college is not given the authority to make such a ban is that we never intended for the college to ban a legal product or to regulate it, and the RHPA did not extend any new powers to any of the colleges to do exactly what this college has asked the government to do. That was, I would say, very much on purpose, because the debate was around the RHPA. Now, if the government then wanted you to have the regulatory authority to start deciding what products your members could sell and not sell, we'd have given it to you then.

**Ms Chamberlin:** I'd like to clarify for you that I am no longer on the college and I do not speak for them.

**Mr Jim Wilson:** You're not on the college. Sorry, and I don't mean to say this in any derogatory way either, but it just strikes me that what we're going through now is the proper course. It strikes me that by not giving the regulatory authority to the regulatory college, it was a recognition by the Legislature that pharmacists are also retailers and that there's another thing that they do out there. Do you have any comments on that?

**Ms Chamberlin:** Probably not the comments that you're looking for. I think it's quite clear that pharmacy is a different kind of profession; the Regulated Health Professions Act covers a number. Pharmacy is not only a professional activity; it also regulates places and things, drugs and drugstores, as well as professional activities. That makes it quite different from a number of the other health care professions.

I do want to clarify that I don't speak for the college. I think your point's an interesting one. I think you are undergoing the correct process. I think, however, that the college, in recognizing the professional responsibility of its members, took the right step in recommending to you that you proceed on this.

**Mr Jim Wilson:** On page 5 of your submission, I guess I have a problem with the fact that we're told time and time again that the public see all pharmacies as health care facilities.

**Ms Chamberlin:** We'd like them to see them as health care facilities. I'm making the point that there is an enormous health care resource available to the public that you're already paying for. If they don't see them as health care facilities and they don't appreciate the quality of information that's available to them there, the public and the system are missing out on an enormous professional health care value that's right there on the street.

**Mr Jim Wilson:** What about these non-traditional pharmacies like Zellers? Surely to goodness people don't see Zellers as a health care facility. They see it as a large department store that happens to have a drug counter.

**Ms Chamberlin:** Under this act I suspect they will no longer have a drug counter at the back.

**Mr O'Connor:** It will place some retailers and pharmacists in a position where they will have to choose between the two. I just wanted to ask for your comment in that we have heard from the college. They had sug-

gested that there be a phase-out, that pharmacists voluntarily phase out the sales of tobacco. In fact, we did have an opportunity to hear from some students of pharmacy who were very supportive of the legislation because they wanted to see themselves as health care professionals.

I tend to agree with you that pharmacists are terrific health care professionals who are there and who quite often are underutilized. People don't always go and talk to their pharmacist and perhaps listen to a suggestion or two that they may have to offer that would undoubtedly save us as taxpayers some money.

The students never said that anywhere in their learning, going through school, they should be looking at just pure marketing of everything. They went through school to be health care professionals. Could you comment on that element further? I appreciate what you have said.

**Ms Chamberlin:** I think you've said it very well. That's absolutely the case. Students are trained to be health care professionals. The fact that pharmacy is a mixed scenario with a business element involved, I think we have to be very careful that the professionalism comes first and, quite frankly, that this province accepts its responsibilities to fund the professional aspects and doesn't leave pharmacists out there swinging in the wind to make a profit or some other way of earning their living than through their profession. I think there is that element of responsibility on the part of the province.

**Mr O'Connor:** An unfortunate incident that did happen was when we had the college and the pharmacists' association before a committee that was looking at reform to the Ontario drug benefit plan and they left the table. That was an unfortunate situation because I was interested in how we could utilize all the elements of the health care training that pharmacists had received. At that point I was disappointed because I truly believe they are health care professionals that have been underutilized and would look forward to expanding discussions with them.

**Ms Chamberlin:** This is a complex issue. This is only one part of it, but it is a significant part of it.

**The Chair:** Thank you very much for coming before the committee today. We appreciate it.

1630

#### SIMCOE COUNTY DISTRICT HEALTH UNIT

**The Chair:** I call on the Simcoe County District Health Unit. Mr Wilson, we're about to get into some good Simcoe county presentations. Welcome. Please introduce your delegation and then go ahead.

**Dr David Butler-Jones:** Certainly. I'm David Butler-Jones. I'm the medical officer in Simcoe county. The committee had the opportunity to hear from me last week, presenting on behalf of ALOHA. I have no intention to repeat that and you'll be thankful for that, I think.

I would like to introduce and we felt that it might be of interest to the committee to hear from Cathryn Rees, who is a public health nurse working in the healthy child and adolescent program of the health unit; also Shelly Howe, who is a grade 11 student at Innisdale Secondary School in Barrie. I'll turn it over to them now.

**Ms Cathryn Rees:** I've been working for 10 years with children and adolescents in Barrie and I'm sensing



and hearing a change in the attitude young people have towards tobacco. The timing is really right for this bill. The majority of the teenagers are in favour. I've prepared a poster here. I thought I would try to speak to all of the points on that poster. Here we've got the "Break Free" and Lung Association poster that many of you have seen, effectively showing the image of the smoking female teen.

The first point over here—we're accumulating more negatives now rather than positives—it's not cool to be poor. Cigarettes are so expensive, teens can't afford to offer them around any more. They often have reduced allowances and many part-time jobs have been eliminated. Buying cigarettes has become a financial hardship. There's very little spending money left for anything else. Keeping the price of cigarettes high has been proven to deter young people from smoking. I'm sure you've heard a lot about that. I'm proud that you're standing firm against the federal government tax reduction.

The next point: It's not cool to be addicted. The high cost of cigarettes is making teen smokers cut down and encouraging many to quit. Students are thus being confronted with the shocking fact that they are addicted much earlier in their smoking careers. Teens are appalled by their addiction to cigarettes. Teens are telling their non-smoking peers and younger students not to smoke. There actually is a cessation group at Innisdale, where I am the nurse, and the students in that group want to go to the elementary schools and talk to the grade 8 classes and tell these students not to start smoking.

Smoking teens have come face to face with the power that addiction holds over them. Teens are no longer feeling they're making their own decisions for themselves; now they're being controlled by cigarettes. Teens who quit state they are proud. Other smoking teens who know they have quit respect them very much for that achievement.

It's too much of a hassle to find somewhere to smoke, the next point. In Simcoe county tobacco use anywhere on school property has been prohibited. Off-school property at Shelly's high school means a significant walk. There is no time for a smoke between classes and snow piles have created further barriers.

There is a momentum towards increasing regulations in our society. It's becoming accepted that a caring community and a caring government would make such laws for the common good and take steps to enforce them. Some examples you'll be very aware of: seatbelt legislation, graduated licensing for teen drivers, RIDE programs, bicycle helmet legislation, planned improvement of enforcement of regulations prohibiting the sale of alcohol to minors, school board prohibitions of tobacco use on school property, municipal bylaws for smoke-free spaces, and now the Ontario Tobacco Control Act.

In Shelly's class I was asking how many of the students were smokers, and 68% in that class were currently smokers; four had been and had quit. I was also asking that class about the bill and asked how many were in favour of raising the age of purchase to 19: 59% were in favour. When Shelly and I were talking she made the very good point that, if the teenagers have to be 19 to

purchase cigarettes, you have fewer of the 16-year-olds or kids who might look 16 who aren't who would be quite likely to buy cigarettes or sell cigarettes to the children who are 11 and 12 years old.

When I asked Shelly's class about the licensing of vendors, 68% were in favour. When I asked them about having stiff penalties for vendors, 68% were in favour. So you can realize that smokers were voting for these controls.

The next point: It might be true that tobacco destroys your health and appearance. This wonderful TV spot from the Ministry of Health has caught many teens' attention. I hear about that when I walk around the high school.

So to conclude my remarks, I say passing this bill is a job for all members of all parties. The bill is needed by the children of the people who elected you. To pass this bill with the full intent takes courage. Be courageous.

Are there any questions you would like to ask Shelly or myself?

**The Chair:** Yes, I'm sure there are, and thank you for that specific information that you've included.

**Mr Jim Wilson:** Dr Butler-Jones, it's good to see you again. Cathryn and Shelly, welcome to the committee. As I'm sure you know quite well, I'm not aware of any members of the Legislature intending on voting against the legislation. In fact, it passed second reading quite easily in the Legislature. We're just trying to fine-tune a bit of it.

Your comments with respect to 68% of Shelly's class who claim they were smokers are most disturbing. It kind of goes in line with a group of young people who appeared before the committee this morning. There were five or six of them who were all smokers and the message I got from them was, nothing seems to be working. The more negative message we send to them, the more rebellious they get and they just want to start because people tell them no.

Back in my days, not too many years ago, the health unit used to come in with a black lung. Was that the health unit, Dr Butler-Jones?

**Dr Butler-Jones:** It would have been the health department then.

**Mr Jim Wilson:** The health department. They used to show us how to brush our teeth back in those days too but that sort of thing didn't seem to have much effect on my generation. I guess it had some effect. The trend has been good but it's sort of bottoming out right at the moment or plateauing, I guess I should say.

We also had the opportunity to ask them whether they thought it would be a good idea if we made the consumption and possession of cigarettes under the age of 19 illegal, much like alcohol. You know, put some responsibility on their shoulders. They made it clear that they just go from retailer to retailer or the black market and eventually they're going to get their cigarettes somewhere. There's no way we could stop them.

I think, Shelly, it's probably your experience and I'd like you to comment on that. Secondly, do you think we

should make it illegal and put some responsibility on their shoulders?

**Ms Shelly Howe:** I know that I've talked to my friends and they said that no matter what they do, they're going to get their smokes from somewhere. It's not going to stop them. There's always someone they can get to buy the smokes for them. But to make it illegal?

**Mr Jim Wilson:** There's one state that I can think of where, in addition to being fairly tough on the sellers of cigarettes, they also have a \$25 fine for the young people, and you have to go down to the police station and pay that \$25 fine. You don't get a criminal record or anything, but it's just a recognition that you have to have to responsibility for what you do. You're not supposed to be buying cigarettes now under the age of 18 or 19. Would that have any effect on your friends, do you think?

**Ms Howe:** I don't think so. I've been talking to them and they said that no matter what you do, they're going to get them. That's just going to make them want to get them more.

**Mr Jim Wilson:** It kind of leaves us in a bit of a predicament.

**Ms Rees:** That is a group of teens and that is their smoking behaviour; it's part of their total lifestyle and it's not just smoking that is part of the lifestyle they have generated. There are other teens who are not following that specific subculture of teens. There are many, many different groups of teens. We have other subcultures of teens who would be intimidated by having to ask someone to buy the cigarettes for them, who would be intimidated by the law as it is stated.

1640

We also really are trying to focus on people who haven't started. We want to increase the hassle and increase the barriers for the people who didn't start. So at the bottom of the poster, it's time to quit for some students if they can manage, and that is awfully hard, but the bottom line is: Better yet, don't start.

This legislation is really going to do a lot for the young people who are not smoking at this point in time. Sure, some of them will enjoy the challenge and will chase after it, but that group will be getting smaller and smaller if we do have this legislation with the intent that is within it.

**Mr Jim Wilson:** I appreciate your comments very much but this legislation doesn't do a heck of a lot, in my opinion, to alter the current model. It raises it one year and teens have told us, "Whoopee ding-dong"; it puts heavier fines on retailers, so maybe they will smarten up, though teens tell us it won't matter; and it has some other provision like vending machines. Less than 1% of cigarettes are sold through vending machines anyway, but I agree we should ban them. We should also compensate the people who own those vending machines.

Pharmacies, okay, if you accept the argument that it will restrict. It's only going to restrict the sale of cigarettes in a small part of a huge retail sector. So I'm in favour of the legislation but I'm missing the boat. I think we need more teeth in it. All we're doing is propagating an old model and putting new clothes on it.

**Dr Butler-Jones:** I think that goes back to the position that you would hear from health units generally that relate to price and availability: the fewer places you can get it, whether it's only in licensed establishments like we talked about last week, the issues that relate to maintaining the price of the cigarettes.

The notion of having a simple fining system, for a 12-year-old that would be a barrier. It may not be for somebody who's already addicted at 15 or 17, but for a 12-year-old looking at the prospect of just having a pack of cigarettes and somebody saying, "That's \$25," then it might be a barrier. Those kinds of things I think are important considerations, and the point is to get them to stop before they even start.

**Mr O'Connor:** I appreciate what you've added to this debate. It's always nice to see young people come forward because it lets us know that we're reaching some of the target that we're trying to reach, and that's our young people. We don't want them to become addicted.

One of the things the bill has in place is an automatic prohibition, and we've also heard there should be a licensing system. Someone today suggested that the licence that hangs up in the corner in the retailer's, that allows that person to have that licence, is kind of an important thing. They thought maybe that's what we should be going to.

I'm not convinced of that. I like the model we've got before us because when you get into the stage of the automatic prohibition, you put a sign in there that says, "This retailer has been selling cigarettes to children under the legal age to sell them." To me, it sends a stronger message out there. Would you not think that we should be trying to send out the strongest message, and would you support that element? You've read the automatic prohibition section. Do you think that's strong enough? I think it's pretty tough.

**Dr Butler-Jones:** I think in that context it's useful. Personally, I think that cigarettes should only be available through LCBOs and beer stores and wine stores so that you overcome the issues of the under-19s, because they have a system in place to deal with that. It is an access issue. As long as you've got corner stores selling cigarettes, you're still going to face that dilemma. I agree. If that's where it's going to stay, then those kinds of prohibitions are important.

**The Chair:** Thank you all for coming before the committee today. We appreciate it.

Members, we have distributed a copy of Bill C-111, which is the bill that was passed in the House of Commons today, just for your information.

#### SIMCOE COUNTY INTERAGENCY COUNCIL ON SMOKING AND HEALTH

**The Chair:** Representatives from the Simcoe County Interagency Council on Smoking and Health, welcome. Please introduce yourselves and go ahead.

**Ms Shawn Fendley:** Thank you very much. It may have been confusing to try and figure out who was who, but I am Shawn Fendley and my colleague is Vito Chiefari. We both come representing the Simcoe County Interagency Council on Smoking and Health, which is a



group that I'm proud to say has been in existence since 1979 and represents people from the Lung Association, the Heart and Stroke Foundation, the Cancer Society, the Addiction Research Foundation, the health unit, both our boards of education, Best Start Barrie, which is a low-birth-weight prevention project initiative in Barrie, the community health centre, some local physicians and some community members at large.

We've worked long and hard over many, many years in the areas of education, cessation support and environmental protection, but our major focus, particularly in the last couple of years, has been on youth and the prevention of smoking starting in the first place.

We truly believe that it's not one initiative alone but our collective efforts of governments, local bodies like ourselves, educators, parents, young people and the community at large that can really make a difference and help our future generations be smoke-free. We really must do all we can to keep our young people from tobacco addiction, which we know is a leading preventable cause of death.

I'm sure you've had many people say to you that with any efforts we can make to keep young people from smoking up into the age of 20, the likelihood of their ever becoming addicted to tobacco is very, very slim. We feel that Bill 119 is a most important piece of legislation that could be considered in Ontario respective to our health. It will complement and strengthen many of the actions that are already under way in communities. We really do need the support of a strong tobacco act to show people and our young people that we really are serious about protecting people's health.

We really do applaud this government for bringing forth and introducing Bill 119 and for the government and the opposition parties to see it passed through second reading and referred to this committee for hearings. Thank you very much for the opportunity today to present our position to you.

Needless to say, with a great focus on youth and prevention of tobacco use, we are very pleased to see the provisions that are looking at reducing young people's access to tobacco, such as increasing the legal age, banning the sale of tobacco in pharmacies and other health facilities, banning vending machines, controlling the illegal sale of tobacco to minors and prohibiting smoking in designated places, including schools.

We are very fortunate. As of September 1993, both our school boards have made it a policy that there's no smoking on any school properties, but we know that there many other communities across this province that don't have such policies in place. As important are the health warnings and the health information that need to be part of packaging and posting where tobacco is sold.

There are some other thoughts that we'd like you to consider in terms of provisions that would be even more helpful in keeping our young people smoke-free, such things as banning countertop, self-service and other point-of-purchase displays and looking at banning any packaging of cigarettes with less than 20 cigarettes.

We just heard from the delegation from the health unit

that one of the critical factors for young people today is the cost. I think the tobacco industry has been creative in looking at ways of trying to beat the increasing cost and the taxes by putting them in smaller portions, which helps when somebody may be thinking of trying out a new habit, may not want to buy a whole pack but a few might be quite interesting, or if you've an established habit and money is low, it might be something that you could continue.

We truly believe that strengthening the designation of smoke-free places in our community in such things as recreational facilities, theatres and shopping malls will also help contribute to our goal to keep our youth smoke-free.

We'd also like you to consider incorporating a minimum of 50% smoke-free seating in banquet halls, food establishments and bingo parlours as a step forward to making more and more community places smoke-free.

I'd like to follow with some arguments for those suggestions and my colleague will carry on as well.

I think one of the things we've talked about is the frustration in realizing that there have been many, many efforts that have been successful in reducing the numbers of adolescents who are smoking in the community, but we seem to have hit a stalemate. I think one of the main reasons we have to look at is the inconsistency of our messages.

We talk about the health hazards and yet it's something that's readily available, easily accessed, marketed very, very attractively and allowed in so many public places. We still know there are a fair number of adults who smoke. It leaves you with that question, if it's so bad for us, then why is this all still happening? I think a point we really need to take into serious consideration is, are we sending consistent messages to our young people?  
**1650**

It's something we battle with every day. I have a nine-year-old daughter and at this point in time it's really not too difficult to talk to her about the hazards of smoking. If you see something or you talk about a neighbour who smokes, it's very easy to rationalize with her some of the hazards and, yes, some people still choose to smoke. But I know as she gets older and the outside messages become stronger, that rationale is going to be much harder to argue. I think the messages need to be far more consistent, because I know my input won't have nearly as much weight in the future. We really need to prove that our talk is not cheap and we must do everything we can to remove the incongruencies.

When we talk about the ease of getting cigarettes, I think you've probably well heard about situations where we know that you're not supposed to be selling tobacco to people under the age of 18 and yet it's very easily accessed. I cited an example in our brief. It was very challenging. We had three headlines on three different pages of the paper. This exercise was done in May of last year. We've got front headlines: "Buying Cigarettes Easy for Teens." The article carries on and says, "Underage Smokers Finding it Easy to Spark Up." The last one says, "Teenagers Treat it as a Game."



I think the frustration was that here was somebody who was only 16 years of age, sent to six locations in our community and had no problem at all in buying cigarettes from any one of those locations. There was a major supermarket, local corner stores and two pharmacies included, and not once did she get questioned or asked to show identification. I think that situation could pretty much be replicated across this province.

We really need to seriously look at it. If we think it's a hazard for young people to access cigarettes, then we need to follow through with that and make sure that the measures that we put into place are enforced.

I know you've also heard lots of arguments about the relationship between tobacco and pharmacies and that message we're sending to people related to tobacco and health. I think it's just another example of the importance of not talking out of both sides of our mouth. If it really is a hazard to our health, then why is it so readily available in what I consider very much a health care facility?

Just to draw it to your attention, we were asked on behalf of an IDA pharmacy, the Piercys in Orillia, to forward a letter to the committee from them about their recent experience of deciding to open a pharmacy in Orillia in 1991, very tough economic times, and deciding not to sell cigarettes and what their experience has been. I'd like to just draw that to your attention.

Then there's the piece about the not-so-subtle marketing. We know that there are things, as mentioned, like kiddie packs and point-of-purchase displays that are very conveniently positioned so that anyone going to the front of the store to make their purchase is going to pass by these displays, and very much at the eye level where many, many young people will see it. Again, they're just things that tend to undermine our messages that tobacco products are a health hazard.

My colleague will talk about smokefree spaces.

**Mr Vito Chieffari:** Thank you to the committee for letting me speak. I think that the bill itself is an excellent piece of legislation. My focus is going to be on environmental tobacco smoke, focusing a lot on section 9 of the act.

I think that, following through with what Shawn's saying about the positive message that we give our kids, the more smoke-free places we create in our society, the better examples we're providing for our youth. I don't have the empirical evidence to show that, but that to me just makes sense.

I'm not here as a medical doctor to talk about the consequences of secondhand smoke. I've read studies talking about secondhand smoke and environmental tobacco smoke linked to lung cancer and respiratory complications and allergies.

The only example I have is my grandmother. This sticks in my mind. In 1976 my grandmother went to the doctor complaining about coughs and sneezing and all kinds of respiratory problems. Her doctor did the routine stuff on her and she said, "Mrs Carnovale, do you smoke?" My grandmother goes, "No, I don't smoke." "No, no, you can tell me the truth. I'm your doctor." My

grandmother says, "No, I don't smoke, but my husband smokes." Of course, my grandfather smoked a pack and a half of Export A a day back in the 1970s.

She came home in tears and really upset about the fact that she was going die on behalf of the fact that he smoked, so he gave up the habit. I never forgot that, and that to me is enough evidence of the consequences of secondhand smoke. My grandfather, of course, died of lung cancer in 1989, and that's another story.

In respect to section 9 of the act, I think it's a great step when we talk about banning smoking in our schools, in our nurseries, our financial institutions, retail outlets, laundries, hairdressers etc. I think we have to add a few to that list, to include recreational facilities such as arenas, theatres and shopping malls. If we're going to make a positive statement out there, let's go the full spectrum.

I think an additional section should be added on to incorporate at least 50% smoke-free sections in places such as banquet halls, food establishments, including restaurants, and bingo parlours. I'll make some arguments around that. Even though you may have heard a lot of arguments around the fact that we should go completely smoke-free in restaurants and places like that—I agree totally—this to me is at least a good first step for us, if we go segregation.

In Simcoe county, just to give you a flavour of the area that I work in, we have a population of roughly 275,000 people. Only 60,000 live in communities where we have bylaws that have any smoke-free requirements in places that people commonly frequent. I can go into any parts of Alliston or Collingwood or parts of Midland and you may have a smoke-free section in a restaurant one day and nothing the next. Those bylaws just aren't there. The province could do great things in that area if it created a province-wide benchmark.

In respect of the people affected by these places, thousands of people go to restaurants on a weekly basis. The kids in Simcoe county pretty well live in our arenas. Whether they're hockey players, figure skaters or just spectators, it's like a second home to many people. If we made them all smoke-free, it'd be a fantastic thing.

Provincial legislation would create a living playing field for everyone. It would tell the rest of the province that this is how we're going to work. It sets a minimum benchmark that everybody has to follow. It creates a great opportunity for the business person to implement this thing because the government says we have to do it and makes that step a lot easier.

In terms of municipalities, a lot of municipalities will probably never see smoking issues as being a priority. If it's not done at the province, it probably won't be done. It's a good step that we're taking here.

In terms of implementation, as a past public health inspector, I worked under smoking bylaws. I think it's something that could be implemented by public health inspectors or bylaw enforcement officers quite easily. I say that with a grain of salt because resources aren't always there. But we deal with the promotion piece of legislation, we deal with the enforcement piece of it. It's

not something where we'd have to set up a new framework of people to implement this act. I think one of the biggest points for creating a strong smoke-free environment piece in the legislation is the fact that society is ready for it. This isn't something that I think this society is going to be up in arms over, because the majority of the population does not smoke. Even smokers, in most cases, don't mind the idea of having a smoke-free place.

In conclusion, I think this is an excellent piece of legislation. Shawn and I, in our work in Simcoe county, talk to hundreds of people during the week. When we bring up Bill 119, they think it's a good thing, no matter who we talk to. There are exceptions, but the majority of people think it's a good thing, smokers and non-smokers.

The other thing is that Bill 119 provides a much-needed piece of legislation to go with everything else that has been done in this province to try to curtail smoking. It complements the promotional piece, all our ads and all the things we're doing in our schools that Cathryn talked about. I think it's a good, complementary piece.

The other thing is that this sends a very clear message. Bill 119 sends a very clear message to the province that we're serious. It sends a very clear message to some of our federal people that we're serious and we're playing ball here with tobacco. Anyway, we're open to any questions.

**Mr McGuinty:** Thank you both very much for your presentation. One thing comes to mind, listening to you, Ms Fendley, with respect to your little account there of the difficulties, the fears that you may feel with respect to your daughter. After having listened to those young people who were here earlier today, particularly if their parents were non-smokers—and I've got some kids of my own, my daughter is now 12 and she is going through, I think, what is a classical transitional phase where the influences outside the home become greater than those inside the home. You're concerned about whether they're going to pick up the habit and I think, in some ways, I guess what I'm really afraid of is Hollywood may start showing kids' heroes smoking. Bogey and Bacall did more for butts than the industry ever did for itself, I think, in some ways.

1700

It would be nice if I could go home and tell my kids, and maybe you could go home and tell your child: "It's against the law. You're under 19, honey, and it's against the law for you to smoke." That means something to my kids. It's very meaningful for them to know that something is contrary to the law. I'm just wondering how you would react to that.

**Ms Fendley:** I think we can all argue, as probably being teenagers once ourselves, that there's that element of intrigue with being against the law. But I think for most of us, that still bears a pretty heavy weight on our shoulders, when we think about doing something or not doing something. For me what it does is send a strong message that it's against the law because we really are concerned about your health and the health of the people of Ontario. It's not because we just don't want you to do something.

**Mr McGuinty:** Right.

**Ms Fendley:** It really again puts the weight behind how committed we are to the health of people in Ontario and to young people.

**Mr Chiefari:** Yes, it sends a clear message that we're serious about what we're doing. Usually, in my estimation, you have to tie some consequence to lawbreaking, whether that be a nasty letter that goes home with parents or whether that be a dollar-figure fine. I think it's something that should be there.

**The Chair:** Thank you. I should offer some hope, as a parent of kids who have passed 9 and 12 that in fact some do reach the point where they're not smoking and they're past that danger zone. I just want to give you both encouragement.

**Mrs Haslam:** No, the danger zone goes to 20, because I'm in the same situation. In your brief you had easy-to-get cigarettes, and they actually got into pharmacies and got cigarettes. Do you know how many or what pharmacies they were?

**Ms Fendley:** I know that from the piece of information that was in the article. One was a Shoppers Drug Mart and one was a Guardian Drug.

**Mrs Haslam:** Shoppers Drug Mart. I can't believe it.

**Mr Wiseman:** No, not Shoppers Drug Mart.

**Mrs Haslam:** Not Shoppers Drug Mart. Okay.

**The Chair:** Thank you very much for coming to the committee today. We appreciate it.

MARK BORUTSKIE

**The Chair:** I then call our final witness for today who has been, I know, sitting back there waiting very patiently. Mr Borutskie, if you would come forward, we want to welcome you as well to the committee. Once you're settled, please go ahead with your presentation.

**Mr Mark Borutskie:** Thank you for this opportunity of allowing me to make this presentation. My name is Mark Borutskie and I am a practising pharmacist and co-owner of McGregor IDA Drugs in Bowmanville.

Originally, I was not going to make a presentation to this committee. However, because of a series of events, I've changed my decision and I feel compelled to give you a balanced opinion on this issue.

In October 1990 members of the Non-Smokers' Rights Association made a passionate presentation to the council members of the Ontario College of Pharmacists. After much debate, the Ontario College of Pharmacists passed a resolution in June 1991 to remove tobacco products from pharmacies. The college council based its decision on a section of the Health Disciplines Act which states that the college's mandate is to serve and protect the public interest.

I was very concerned with the college's decision, particularly that the council was making decisions about the removal of a legal product because that product may not serve and protect the public interest. My concern was that, if the college made a decision on tobacco in June 1991, what contentious product would it take issue with tomorrow?

I felt that the college had made the wrong decision. I



decided to join together with the Committee of Independent Pharmacists. In August 1991, the elections for the Ontario College of Pharmacists were being held and I decided to stand against the sitting member from my district. I did so because he was one of the council members who voted in favour of the removal of tobacco.

My feelings then, as they still do now, remain the same. If the ultimate purpose of the proposed legislation is to decrease the number of smokers in the province, then I truly believe it will not be achieved. The sales of tobacco products will simply move to the corner store or down to the large grocery store. To simply close one type of tobacco retail outlet and have those sales reappear at another type of outlet appears to be only a lateral move towards combating tobacco use.

My district extends from around Kingston and Gananoque and moves west to include Durham region. There are over 600 pharmacists in district 2. Many pharmacists were upset about the unfair way the council had dealt with this matter. There was no prior canvassing of our membership regarding their feelings on this issue.

My support in the district was reasonably strong. The incumbent member decided not to stand and I was elected unopposed. I've been a council member since October 1991. In fact, you should know that of the nine college council members who voted for the removal of tobacco in June 1991, eight of those councillors were out of office after the August 1991 elections. When I got to college, together with my colleagues, we tried to set in motion the process to overrule the tobacco vote. However, we discovered this was not as simple as it sounded.

The council of the Ontario College of Pharmacists is made up of elected members representing 16 districts. They are voted in by the approximately 8,000 pharmacists registered with the college. If a vote were taken today with the 16 elected members, I believe the tobacco decision would be overturned. In addition to the elected members, the college includes seven non-elected members.

Time and time again this matter has been discussed and debated at college council meetings. In each case the motion to reverse the decision has been defeated. However, I feel these defeated motions do not truly represent the wishes of the majority of pharmacists in Ontario.

I spoke earlier about a change in the council members. Most of the votes cast in the August 1991 elections were made in favour of those candidates who wanted to leave tobacco in drugstores. The Ontario Pharmacists' Association held a referendum in the fall of 1993 on this issue and 62% voted in favour of voluntary removal of tobacco as opposed to legislated removal.

There are about 1,400 pharmacies in the province out of 2,200 which sell tobacco. That's 64% of the profession selling the product. Actually, when you consider that about 250 of these 2,200 pharmacies are located in hospitals, the percentage selling tobacco rises to about 75%.

This is a very divisive issue with many groups. One thing I know we all agree with is that we, as health care professionals, would like to work with everyone towards

reduction in tobacco consumption. As pharmacists, we want to play our part to ensure that minors do not start smoking. Raising the age to 19 is a good start. If there only was a way to make it an offence to smoke under 19, that would make government's endeavours more effective, but obviously that could never be enforced.

Ladies and gentlemen, I'm telling you that this is not what our profession or today's elected college members want you to do. We are a house divided. The majority of pharmacists in this province do not want you to proceed with the pharmacy provision.

**1710**

I'm aware of a report prepared by Coopers and Lybrand detailing the economic impact of the legislation on pharmacies. They predict that about 110 drugstores in the province will close and between 1,300 and 1,500 jobs will be lost. Some of those positions will be pharmacists. Pharmacies closing down and pharmacists and other full-time employed people losing their jobs is not necessary.

Will it reduce smoking? You know it won't. I think I'm well regarded and respected by my colleagues, as evidenced by the fact that elections again were held in August 1993 and this time I was opposed by a pharmacist who advocated tobacco removal, yet I won a convincing majority. I really do stand before you as a representative of the Ontario College of Pharmacists who has been put to the test of his peers and who does represent their views. Their vote is not to proceed with your legislation as it relates to tobacco in pharmacies.

Section 4(2)8 should be taken out, but the rest of your legislation should go forward. Once again, I would like to thank you all for the opportunity of making this presentation today. I only hope I have brought some balance to your committee and that you make a decision which is fair and truly represents our profession.

**Mr McGuinty:** Thank you very much, Mr Borutskie. I think you were helping to lend some insight into an area which I certainly find confusing. That is, we're told that in 1990 or 1991 the college council requested that the government ban, through legislation, the sale of tobacco products in pharmacies, yet we've been besieged by a number of presenters who are obviously against that, so it's obviously a source of controversy within the profession.

There have been informal surveys done by members, people sitting on the committee, and they frankly admitted that they weren't scientific, so I'm not sure how much weight we can put on them. So it's good, I guess, to get some information from somebody on the inside at this particular stage. How many council members that are sitting are appointed?

**Mr Borutskie:** According to the Health Disciplines Act, right now there are six, but of course that's going to change come the fall, I believe.

**Mr McGuinty:** Just now, I mean.

**Mr Borutskie:** There are six sitting right now.

**Mr McGuinty:** Are any of those pharmacists?

**Mr Borutskie:** No. Six public members with 16 elected pharmacists.



**Mr McGuinty:** All right, well, let's just talk the pharmacists for now. You're telling me if we had a vote just among the pharmacists, you're convinced that—

**Mr Borutskie:** Nothing's guaranteed, but I think it would pass.

**Mr McGuinty:** But what's your district?

**Mr Borutskie:** I think they would be in favour. When I read the survey by the Ontario Pharmacists' Association, where they arrived at about 64%, or whatever I said, in favour of voluntary withdrawal of tobacco products, I think that's pretty close to the mark.

Certainly I've had members who called me, knowing I was going to be here, telling me their concerns too, and certainly there were a number who disagreed, who agreed with the government's position of taking tobacco out of pharmacies completely. I see both sides and I'm trying to represent the majority of the pharmacists in my district.

**Mr McGuinty:** That survey you referred to, when was that done?

**Mr Borutskie:** September, I think.

**Mr McGuinty:** That's the most recent one?

**Mr Borutskie:** I think it is. I'm pretty sure it was September 1993.

**Mr McGuinty:** That was conducted by the college?

**Mr Borutskie:** No, by the Ontario Pharmacists' Association. It wasn't done by the college.

**Mr O'Connor:** Thank you for coming before us today. Does the area you represent cover York region as well?

**Mr Borutskie:** No, it doesn't.

**Mr O'Connor:** We had a presentation earlier today by the public health department from York region. They did their own survey and it was a random telephone survey. They phoned 40 pharmacies across York region. Some 90% of the pharmacists' employees supported the ban. A sample of the 39 pharmacies did not sell tobacco products. These pharmacies reported positive comments from their customers and other health care professionals.

A further 40% supported the withdrawal of tobacco products and in fact 15% had already started the plan to remove it before the legislation has been enacted. Some of them even stated that they did so in fear of perhaps losing profits, but of course the lost tobacco sales were not great enough to cause any true economic hardship for those that had reported.

A question I've got for you is, we're trying to deal with this here. We've heard from other people from the college, but we've also heard from the students of pharmacy. It was tremendous. You know, I always get enthused when young people come to the committee, because often we're talking about legislation that's going to be in the books for many years and we're talking about young people.

Maybe you've done this survey. Have you gone to the students of pharmacy and suggested, "Should we continue the sale of this lethal product?" Did you survey them as well in the survey that you did? I know that the students, until they become pharmacists, don't actually become regulated by the college of pharmacy and don't have

representation there, but I just wondered about your thoughts on that.

**Mr Borutskie:** The survey that I mentioned was done by the pharmacists' association. I don't know whether they did survey students. I don't have that information. For what it's worth, certainly I got some feedback from my own kids. They knew I was coming down here and—

**Mr O'Connor:** Are the students of pharmacy?

**Mr Borutskie:** No.

**Mr O'Connor:** Not following in dad's footsteps.

**Mr Borutskie:** One's in high school and one's in college. But I ran it by them, what I was doing. Neither of them smokes. They're dead against smoking for sure, but they agreed with the main thrust of why I'm here, the removal of a legal product. The sales part is an issue. I mentioned it. It's not as important to me; I see tobacco sales shrinking. I don't think in our store we're going to be selling any tobacco in five years anyway because the sales are just diminishing. To give you an idea, sales of tobacco in my store are 3%, and they're going to be less than 1%.

**Mr O'Connor:** The students of pharmacy that we had here were clearly in support of the ban of the sale of this lethal product in pharmacies because they see it as a contradiction. They fully support the legislation because they see themselves, as students, as young people now studying and wanting to become health care professionals, in an ethical dilemma. They definitely supported wholeheartedly the ban on pharmacies, so perhaps you may want to go and talk to them as well. We have heard from them as well, so I appreciate that.

**Mr Borutskie:** Just one extra thing to mention. There are many drugs that come out on the market that people might find offensive. There's a new drug which certainly hasn't been released in Canada, but it's been out in Europe. I don't know if you're aware of it. It's called RU486. It's an abortion pill. When that's released, if it ever is, in Canada, there are going to be a number of pharmacists who because of their views on this, again a very contentious issue—everybody has their own feelings about abortion, of what to do. That will be another dilemma.

Would the government give you any support, any guidelines, as far as, you know, "If you don't believe in the drug, how can you hand it out?" Again, I don't know. It's a lethal product, but if a doctor orders it, it's an issue that a lot of pharmacists, and the students when they get out, will have to deal with, because it will probably be available when they're out in the workforce.

**Mrs Cunningham:** Since this bill is intended to prevent the provision of tobacco to young persons—we personally don't think that saying that pharmacies can't sell them would help us in that regard, because we think people would go down in another part of the mall or whatever, but that's just our position. Have you thought about licensing retailers in order to sell tobacco?

**Mr Borutskie:** As a liquor control board type outlet?

**Mrs Cunningham:** Yes.

**Mr Borutskie:** I've thought of it. I see nothing wrong

with it at all. If it was going to be a level playing field, certainly, where it was sold in outlets, I'm in agreement.

**Mrs Cunningham:** Have you thought about young people being responsible, who would come into your store or anywhere else, to the extent that if indeed they were able to purchase or were found with cigarettes on their person and they were under the age of 19, there would be possible sanctions against people who are smoking and have purchased underage?

**Mr Borutskie:** I've thought of that. I don't know how you'd enforce it. It would be very difficult to enforce, just like the suggestion was made to me to ban smoking in all public places. You could only smoke in your car and in your house; you couldn't smoke outside on the street. That would eliminate a lot of smoking.

**Mrs Cunningham:** You'd have to carefully define "public places." But the reason we're putting this to you is that there have been arguments on both sides, and I think the one is that if you really believe a pharmacy is a health care centre, then you wouldn't sell cigarettes, but pharmacists have come forward and told us they don't believe that's what a pharmacy is in their instance.

To me, that argument's irrelevant. I'm talking about who should be selling, and I don't think any retailers should be told by the government of Ontario that they

can't sell certain products. In this instance we're thinking about licensing certain places, and you've answered that question. But I think you also have to think about the young people who purchased the cigarettes regardless, and what their responsibility is.

I think we have to take those kinds of tough stands if we're going to ban the sale of cigarettes to people under the age of 19. It has to be both sides and there have to be some sanctions. When you go back to your professional organization, I would hope that you would look at those two questions and help us out and give us some recommendations. There have to be responsibilities on both sides.

**Mr Borutskie:** I agree with you.

**The Chair:** Thank you very much for coming before the committee. We hope whatever the weather's doing out there, you have a safe trip home.

**Mr Borutskie:** Thank you very much.

**Mr Wiseman:** It's not doing much.

**The Chair:** Somebody has reported it's not doing much. That's good news. Just before we adjourn then, the committee will be in Sudbury tomorrow and we will reconvene here Thursday morning at 10 o'clock.

The committee adjourned at 1722.









## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)  
Carter, Jenny (Peterborough ND)
- \*Cunningham, Dianne (London North/-Nord PC)  
Hope, Randy R. (Chatham-Kent ND)
- \*Martin, Tony (Sault Ste Marie ND)
- \*McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)  
Owens, Stephen (Scarborough Centre ND)
- \*Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

\**In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Haslam, Karen (Perth ND) for Ms Carter  
Huget, Bob (Sarnia ND) for Mr Hope  
Wiseman, Jim (Durham West/-Ouest ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

O'Connor, Larry, parliamentary assistant to the Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Boucher, Joanne, research officer, Legislative Research Service



# CONTENTS

Tuesday 8 February 1994

<b>Tobacco Control Act, 1993, Bill 119, <i>Mrs Grier</i> / <b>Loi de 1993 sur la réglementation de l'usage du tabac,</b></b> projet de loi 119, <i>M<sup>me</sup> Grier</i> .....	S-913
Halton regional health department .....	S-913
Sandra Murphy, public health nurse	
Kian Higgins, high school student	
Jenny Kang, high school student	
Daryll Gordon, high school student	
Annie Stokan, high school student	
Bobbi MacNeil, high school student	
Katherine Verge, high school student	
Halton Council on Smoking and Health .....	S-916
Joyce See, chairperson	
Edith Telford, volunteer	
James Gay .....	S-918
Simcoe-Matic Canteen Ltd .....	S-919
Jim Dykes, owner and president	
Cathy Jaynes; Salem Khamis .....	S-922
Canadian Cancer Society, Ontario Georgian Lakelands region .....	S-924
Gretta Gill, president	
Ontario Federation of Home and School Associations .....	S-926
Norma McGuire, immediate past president	
Ruth Woodcock, first executive vice-president	
Peterborough County-City Health Unit .....	S-928
Christine Finlan, health promoter, tobacco use prevention program	
Leslie Braden .....	S-930
Canadian Cancer Society, Ontario central west region .....	S-932
Bonnie Hauser, chair, health promotion	
Howard Lackie .....	S-934
Meri Bukowskyj .....	S-936
Council for a Tobacco-Free Ontario .....	S-939
Alwyn Robertson, executive director	
Dr Michael Goodyear, vice-president, public affairs	
George Phillips .....	S-942
Haliburton, Kawartha, Pine Ridge District Health Unit .....	S-944
Bill Wensley, board vice-chair	
Psychiatric Patient Advocate Office .....	S-945
David Giuffrida, acting director	
Duff Waring, systemic policy adviser and acting legal counsel	
Kohl and Frisch Ltd .....	S-948
Ronald Frisch, chief executive officer	
Jane Chamberlin .....	S-951
Simcoe County District Health Unit .....	S-953
Dr David Butler-Jones, medical officer of health	
Cathryn Rees, public health, healthy child and adolescent program	
Shelly Howe, high school student	
Simcoe County Interagency Council on Smoking and Health .....	S-956
Shawn Fendley, member	
Vito Chiefari, member	
Mark Borutskie .....	S-958

432100051













3 1761 11467163 9